DOCUMENT RESUME

ED 408 503 CE 074 331

AUTHOR	Louis, Donald R.; Resendiz, Rosalva
TITLE	Sensitizing Police Officers to Persons with Developmental Disabilities. A Curriculum Guide for Law Enforcement Trainers.
INSTITUTION	North Texas Univ., Denton.
SPONS AGENCY	Texas Higher Education Coordinating Board, Austin.
PUB DATE	Feb 97
NOTE	287p.
PUB TYPE	Guides - Classroom - Teacher (052)
EDRS PRICE	MF01/PC12 Plus Postage.
DESCRIPTORS	Autism; Behavioral Objectives; Cerebral Palsy; Consciousness Raising; *Continuing Education; Curriculum Guides; *Developmental Disabilities; Disability Discrimination; *Disability Identification; Epilepsy; Hearing Impairments; Instructional Materials; *Interpersonal Competence; Learning Activities; Mental Retardation; Police; *Police Community Relationship; *Police Education; Social Attitudes; Staff Development; Teaching Guides
IDENTIFIERS	Texas

ABSTRACT

These three documents (a curriculum guide and two learning guides) are designed for use in police academies in Texas for advanced officer training. The curriculum guide provides a comprehensive training program designed to give police officers a working knowledge and understanding of how to interact while in the line of duty with persons who have disabilities. Designed for one 8-hour session, the material is organized into six major sections: (1) an overview of developmental disabilities (DD); (2) mental retardation; (3) autism; (4) cerebral palsy; (5) epilepsy; and (6) hearing impairments. Each section is designed to meet the specific objectives of assisting with identification of and communication with persons with DD. Each section includes performance and enabling objectives, lecture material, and suggested activities. All transparency masters are found at the end of the guide. The first learning guide is designed as a train-the-trainer guide. Divided into tasks, the guide provides for each task these materials: introduction; performance and enabling objectives; prerequisites; check list; key points; self-check with answer key; learning experiences, including role playing; and performance test. The second learning guide is designed as a handout for the advanced officer's training. For each topic, these materials are provided: objectives, information, and suggested activity. A quiz is appended. Contains 23 references. (YLB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 408 503

SENSITIZING POLICE OFFICERS TO PERSONS WITH DEVELOPMENTAL DISABILITIES

A Curriculum Guide for Law Enforcement Trainers

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY
S B Rester
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

University of North Texas

Department of Rehabilitation, Social Work and Addictions

Donald R. Louis
Rosalva Resendiz

February, 1997

CE 074 331

BEST COPY AVAILABLE

ACKNOWLEDGMENTS

This project would not have been possible without the contributions of many persons, whom we would like to acknowledge. First, credit goes to the Texas Higher Education Coordinating Board for its support. The project reflects the Board's continued mission of workforce development, particularly through technical education. The project staff gratefully acknowledges a large debt of gratitude to the Project Advisory Committee members listed below. Their wisdom, accompanied by long hours of active involvement, carefully guided this training project.

Project Advisory Committee

Craig Campbell, Ph.D.
TCLEOSE
Austin, TX

Bonnie Lewallen
The Arc of Denton County
Denton, TX

Leigh Ann Reynolds
The ARC of the United States
Arlington, TX

Lin Jones, Director
UNT Police Academy
Denton, TX

Peggy Heinkel-Wolfe
UNT College of Music
Denton, TX

Joe Foley,
Vernon Regional Junior College
Wichita Falls, TX

Roger Labodda
THECB
Austin, TX

Martha Sabin
Beaumont State Center
Beaumont, TX

Ted Phillips
Tarrant Co. Junior College, NW
Fort Worth, TX

John Sheppard
Cedar Valley College
Lancaster, TX

Jeanie Pemberton
Interagency Council on Autism
Lewisville, TX

Mike Regan
NCTCOG Regional Police Academy
Arlington, TX

A special thanks is owed to the following faculty from the University of North Texas: Lindsey L. Jones, Peggy M. Heinkel-Wolfe, and Thomas L. Evenson. They are "Doers" in the truest sense. They engage in the kinds of endeavors that promise a better future for persons with life-long disabilities and personnel employed in the criminal justice system. They helped move the germ of an idea to its successful application, frequently in creative ways never before tried or perceived as possible. They helped maintain momentum and handled the unforeseen; they coordinated, made linkages, and broke down tasks into workable pieces. Neither theoretical insight nor inspired rhetoric is enough to cause social change. Someone has to take the necessary steps to give an idea flesh and they filled this role in a very superb manner.

Table of Contents

page

Introduction iv
How to use this material vi
Suggested schedule vii
Developmental Disabilities 1
- Identification of a person with DD 3
- Background information 4
- DD defined 5
- Why training is important to police officers 6
- Categories of DD 9
- Prevalence rates of DD 11
- Offenders with DD 13

Mental Retardation 15
- Identification of a person with M-R 16
- M-R defined 20
- Below average intellectual functioning 21
- Prevalence rate of M-R 21
- Adaptive Behavioral Functioning 23
- Manifests before age 18 24
- Police situations with a person with M-R 24
- Communicating with a person with M-R 26
- Community resources for a person with M-R 30

Autism 31
- Identification of persons with autism 32
- Characteristics of autism 31
- Impaired social behavior 32
- Impaired language skills 33
- Autism and repetitive activities 34
- Major aspects of autism 34
- Prevalence of autism 37
- Intelligence and autism 37
- Causes of autism 38
- Physical differences 39
- Sensory Impairments 40
- Communicating with persons with autism 42
- Community Resources 43

Cerebral Palsy 44
Identifying persons with CP 45
What is cerebral palsy 46
Prevalence rates of CP 48
Types of CP 49
Conditions that accompany CP 50
Community resources for persons with CP 51
Epilepsy 54
Identifying persons with epilepsy 54
What is epilepsy 55
Seizures and epilepsy 56
What causes epilepsy 57
How is epilepsy diagnosed 57
How is epilepsy treated 58
Prevalence rates of epilepsy 59
Types of seizures 60
Responding to persons during a seizure episode 63
Mental illness, intoxication and seizures 61
Police involvement 67
Where and when do police encounters occur 68
Resources for persons with epilepsy 68
Hearing Impairments 70
Identifying the hearing impaired 70
Background 71
Definitions for deafness and hearing impairment 72
What causes hearing loss 73
Types of hearing disorders 73
Prevalence of hearing impairments 74
Additional disabling conditions 75
Police encounters 76
Types of communication 77
Communication tips 78
Community resources 79
References 81

Source of three videos that are recommended.

Officer's Guide: Interacting with Disabled People (1991)
Dayle McIntosh Center for the Disabled
150 W. Cerritus, Bldg. 4
Anaheim, CA 92805
Contact Norm Savage, ADA Project Coordiantor
Telephone: 714-772-8285
Costs: $49.95

Making Contact: Communicating with Adults with Mental Retardation
Suncoast Media
12551 Indian Rocks Road #15
P.O. Box 990
Largo, Florida 34649
Telephone:

Police Response to Seizures and Epilepsy: A Curriculum Guide for Law Enforcement Trainers
Police Executive Research Forum
2300 U Street, N.W., Suite 910
Washington, D.C. 20037
Telephone: 202-466-7820
Fax: 202-466-7826
Costs: $10.00 plus $3.75 for shipping.

Introduction

Police work is very complex in that it requires a constant and changing responsiveness to circumstances, and further, the community policing model is placing new and additional demands on police officers. Regardless of the model with which the officer is working, the police play a central role in our democratic society. The police are called upon to enforce our laws, to observe constitutional restraint upon the exercise of governmental power, to answer individual calls for help and to respond to community demands for safety.

According to Jeremy Travis, Director of the National Institute of Justice, "of all governmental operations, the police function is the most intimate–the daily, varied encounters between police officers and individuals, ranging from routine to traumatic, represent the most visible and powerful interactions between the government and the public. If the police perform their role effectively, our society benefits immeasurably; if the police perform their role poorly, the damage to public confidence and democratic principles can be irreparable (p.1)."

America develops yardsticks for its major concerns. We measure everything from the productivity of factory workers to rates of infectious illness to the endurance of athletes. A wave of concern is elevating to consciousness the injustices, frequently and perhaps very innocently, dealt to persons with developmental disabilities that confront the criminal justice system. A lack of awareness regarding the nature of disabling conditions, the existence of services, the need for special programs for offenders with life-long disabilities and the inability to recognize behavior that signals a need for special evaluation of an accused have been found nationwide. This lack of awareness has contributed to persons with developmental disabilities suffering gross injustices which far exceed the injustices suffered by any other class of offenders. This training material is not designed to advocate for a dual standard, rather that an increased understanding by police officers of the unique characteristics of persons with life-long disabilities might contribute to their experiencing equal justice.

The road from institutionalization to community inclusion for persons with any of the cluster of developmental disabilities (DD) has been long, complex and fraught with unforeseen difficulties. The policies of deinstutionalization, first implemented over 25 years ago and designed to transfer the care of persons with developmental disabilities from large state institutions to local communities, have affected many public and private groups of society. A few groups have found themselves with a disproportionate amount of additional responsibilities not always with a concomitant allocation of resources. The various levels of law enforcement are reflective of this action as personnel was left untrained regarding the unique characteristics of persons with life-long disabling conditions.

One such problem is the percentage of persons with developmental disabilities confronting the criminal justice system which is frequently reported as approaching seven times the corresponding number in the general population. At the same time, most authorities argue that those with life-long disabilities are no more likely to commit crimes than the non-disabled.

Community inclusion implies that persons with DD are both **in** and **of** the community. As citizens they are entitled to the same rights and privileges under the law as the non-disabled. Currently, in most states, criminal justice personnel receive adequate training on mental illness, yet virtually no training about the characteristics of persons with DD. This absence of training has led to undue hardships for the DD community in experiencing equal treatment within the criminal justice system.

Because of community inclusion, on any given shift, the possibilities that law enforcement officers may encounter persons with life-long disabilities is greater than it has ever been. Many police authorities report that as much as 80 percent of police calls and accompanying responses do not involve a criminal act. Thus normal policing activity will expose officers to encounters with persons exhibiting confused behavior, an inability to communicate or a variety of behaviors inappropriate to time and place. There may be many causes of behavior of which some are indeed illegal, however the majority of instances involve persons with impaired mental and physical abilities.

Many of the problems that surface for law enforcement officials are due to the officers' unfamiliarity with the real nature of these episodes. Police may interpret dazed behavior, inability to obey directives and a combative response to restraint as conscious actions. Police are likely to react with force and may try to arrest the person who perhaps is having a seizure (as an example). Such response is humiliating to all persons involved and may precipitate unwanted injury and lawsuits. In a few instances, the failure to recognize a developmental disability has had fatal outcomes.

The key to a more appropriate law enforcement response to the five percent of the population with life-long disabilities is training. Such training involves a basic understanding of the major categories and how to identify each, accompanied by appropriate communication strategies. This material is designed to give the law enforcement officer an additional tool when responding to a call involving a person with DD.

Law enforcement officers are likely to encounter people with DD in a variety of settings and circumstances. The aim of this material is not to suggest that every episode involving a person with DD is justified, which would be both incorrect and unrealistic. Rather the intent is to raise law enforcement officers' awareness of the possibility that the persons, are in fact persons first, and that they possess unique traits that require understanding.

Although implementation of a new approach (paradigm) cannot be accomplished overnight, planning efforts that ignore an emerging paradigm build obsolescence into future plans. Persons with disabilities are citizens, entitled to full protection, rights and privileges under the law. Consequently, the need for informed and sensitive police officers is self-evident.

"Sensitizing Law Enforcement Officers To Persons with Developmental Disabilities" is a comprehensive training program for police officers designed to increase the officer's awareness of the unique characteristics of persons with life-long disabilities. The goal of the material is to give officers a working knowledge and understanding on how to interact while in the line of duty with persons who are disabled. The background material gives a brief overview of the characteristics and ramifications of each of five categories of disabilities with the highest prevalance rates and as recommended by focus group participants.

How to Use this Material

This material was developed so as to be self-contained, with this being the instructor's material and with a separate trainees guide for participants. At various interval in the material, a reference is given to a specific page in the learner's guide for participants to turn to for the completion of an activity. Individuals who train law enforcement officers to handle calls involving persons with developmental disabilities should possess a mixture of skills and information, along with specific knowledge about law enforcement and the criminal justice environment. In addition to being able to lead a discussion and encourage increased awareness, the trainer should display sensitivity to law enforcement officers training needs and personal biases.

The material was designed for one (1), eight (8) hour session of advanced law enforcement officer training in the state of Texas. It contains six major sections that are the result of state-wide fact finding research undertaken by the authors prior to the development of this material. While developmental disabilities are numerous by categories, the authors' findings from five community forums held in key Texas cities suggested that five major categories should be addressed. This material is organized by beginning with (1) an overview of DD, followed by sections on (2) mental retardation, (3) autism, (4) cerebral palsy, (5) epilepsy and (6) hearing impairments.

Confucius (551-479 B.C.), the Chinese philosopher gave words of wisdom that have stood the test of time in professional training. He said, *what I hear I forget, what I see I understand, what I do I remember*. This material contains elements of all three as it includes lecture material assisted with a generous number of transparencies to emphasize key points. In addition, it includes the use of three videos and a brief activity at the close of each of the six sessions.

Each section of this course is designed to meet the specific objectives of assisting with identification and communication with persons with developmental disabilities. The objectives are of two broad types. The first type refers to what officers should know about responding to persons with DD, and the second is to give them an opportunity to practice using the material just covered.

It is also suggested, that the instructor use one of several possible methods to acquaint participants with local and regional resources. One method may possibly be the use of a handout containing a list of agencies such as the nearest MHMR office and agencies such as the local chapter of United Cerebral Palsy, the Autism Society, etc. Another suggestion could be the use of a speaker such as a representative of the local community-based MHMR agency making a brief presentation during one of the sessions focusing their remarks on resources available in that community for persons with developmental disabilities. Lastly, a successful technique appears arranging for a few adults with life-long disabilities to visit the session in its closing momemts. This gives officers a close-up perspective that they might otherwise not ever experience.

Evaluation of this session will consist of two parts. We are asking for you to administer a 25 item true-false test prior to the beginning of the session and the identical instrument again at the close. Ask the participants to place their initial in the upper right hand corner for ease of matching instruments for comparison purposes. This will give the authors a chance to examine the effectiveness of the material. In addition, we are asking that the second quiz be accompanied by a one page questionnaire whereby participants can quickly and anonymously give their evaluation regarding the effectiveness of the session.

Suggested Schedule

The following schedule is suggested, assuming that the session is for eight hours.

8:00 - 8:10	Introduction and give first quiz.
8:10 - 8:20	Outside speaker giving overview of community resources
8:20 - 9:10	Lecture on **Developmental Disabilities**
9:10 - 9:25	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
9:25 - 9:35	Break
9:35 - 10:30	Lecture on **Mental Retardation**
10:30 - 10:45	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
10:45 - 10:55	Break
10:55 - 11:45	Lecture on **Autism**
11:45 - 12:00	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
12:00 - 1:00	Lunch Break
1:00 - 1:55	Lecture on **Cerebral Palsy**
1:55 - 2:10	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
2:10 - 2:20	Break
2:20 - 3:15	Lecture on **Epilepsy**
3:15 - 3:30	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
3:30 - 3:40	Break
3:40 - 4:30	Lecture on **Hearing Impairments**
4:30 - 4:45	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
4:45 - 5:00	Second quiz and course evaluation

The following videos are recommended:

Officer's Guide: Interacting with Disabled People

Making Contact: Communicating with Adults with Mental Retardation

Take Another Look - Police Response to Seizures and Epilepsy

It is also suggested that one outside speaker be used that can speak briefly on available community resources in the local community or county. Possible speakers may be from the local community-based MHMR agency, Goodwill Industries, local chapters of The Arc, Autism Society, Cerebral Palsy or a provider of specialized housing.

Introduction

Police work is very complex in that it requires a constant and changing responsiveness to circumstances, and further, the community policing model is placing new and additional demands on police officers. Regardless of the model with which the officer is working, the police play a central role in our democratic society. The police are called upon to enforce our laws, to observe constitutional restraint upon the exercise of governmental power, to answer individual calls for help and to respond to community demands for safety.

According to Jeremy Travis, Director of the National Institute of Justice, "of all governmental operations, the police function is the most intimate–the daily, varied encounters between police officers and individuals, ranging from routine to traumatic, represent the most visible and powerful interactions between the government and the public. If the police perform their role effectively, our society benefits immeasurably; if the police perform their role poorly, the damage to public confidence and democratic principles can be irreparable (p.1)."

America develops yardsticks for its major concerns. We measure everything from the productivity of factory workers to rates of infectious illness to the endurance of athletes. A wave of concern is elevating to consciousness the injustices, frequently and perhaps very innocently, dealt to persons with developmental disabilities that confront the criminal justice system. A lack of awareness regarding the nature of disabling conditions, the existence of services, the need for special programs for offenders with life-long disabilities and the inability to recognize behavior that signals a need for special evaluation of an accused have been found nationwide. This lack of awareness has contributed to persons with developmental disabilities suffering gross injustices which far exceed the injustices suffered by any other class of offenders. This training material is not designed to advocate for a dual standard, rather that an increased understanding by police officers of the unique characteristics of persons with life-long disabilities might contribute to their experiencing equal justice.

The road from institutionalization to community inclusion for persons with any of the cluster of developmental disabilities (DD) has been long, complex and fraught with unforeseen difficulties. The policies of deinstutionalization, first implemented over 25 years ago and designed to transfer the care of persons with developmental disabilities from large state institutions to local communities, have affected many public and private groups of society. A few groups have found themselves with a disproportionate amount of additional responsibilities not always with a concomitant allocation of resources. The various levels of law enforcement are reflective of this action as personnel was left untrained regarding the unique characteristics of persons with life-long disabling conditions.

One such problem is the percentage of persons with developmental disabilities confronting the criminal justice system which is frequently reported as approaching seven times the corresponding number in the general population. At the same time, most authorities argue that those with life-long disabilities are no more likely to commit crimes than the non-disabled.

Community inclusion implies that persons with DD are both **in** and **of** the community. As citizens they are entitled to the same rights and privileges under the law as the non-disabled. Currently, in most states, criminal justice personnel receive adequate training on mental illness, yet virtually no training about the characteristics of persons with DD. This absence of training has led to undue hardships for the DD community in experiencing equal treatment within the criminal justice system.

Because of community inclusion, on any given shift, the possibilities that law enforcement officers may encounter persons with life-long disabilities is greater than it has ever been. Many police authorities report that as much as 80 percent of police calls and accompanying responses do not involve a criminal act. Thus normal policing activity will expose officers to encounters with persons exhibiting confused behavior, an inability to communicate or a variety of behaviors inappropriate to time and place. There may be many causes of behavior of which some are indeed illegal, however the majority of instances involve persons with impaired mental and physical abilities.

Many of the problems that surface for law enforcement officials are due to the officers' unfamiliarity with the real nature of these episodes. Police may interpret dazed behavior, inability to obey directives and a combative response to restraint as conscious actions. Police are likely to react with force and may try to arrest the person who perhaps is having a seizure (as an example). Such response is humiliating to all persons involved and may precipitate unwanted injury and lawsuits. In a few instances, the failure to recognize a developmental disability has had fatal outcomes.

The key to a more appropriate law enforcement response to the five percent of the population with life-long disabilities is training. Such training involves a basic understanding of the major categories and how to identify each, accompanied by appropriate communication strategies. This material is designed to give the law enforcement officer an additional tool when responding to a call involving a person with DD.

Law enforcement officers are likely to encounter people with DD in a variety of settings and circumstances. The aim of this material is not to suggest that every episode involving a person with DD is justified, which would be both incorrect and unrealistic. Rather the intent is to raise law enforcement officers' awareness of the possibility that the persons, are in fact persons first, and that they possess unique traits that require understanding.

Although implementation of a new approach (paradigm) cannot be accomplished overnight, planning efforts that ignore an emerging paradigm build obsolescence into future plans. Persons with disabilities are citizens, entitled to full protection, rights and privileges under the law. Consequently, the need for informed and sensitive police officers is self-evident.

"Sensitizing Law Enforcement Officers To Persons with Developmental Disabilities" is a comprehensive training program for police officers designed to increase the officer's awareness of the unique characteristics of persons with life-long disabilities. The goal of the material is to give officers a working knowledge and understanding on how to interact while in the line of duty with persons who are disabled. The background material gives a brief overview of the characteristics and ramifications of each of five categories of disabilities with the highest prevalance rates and as recommended by focus group participants.

How to Use this Material

This material was developed so as to be self-contained, with this being the instructor's material and with a separate trainees guide for participants. At various interval in the material, a reference is given to a specific page in the learner's guide for participants to turn to for the completion of an activity. Individuals who train law enforcement officers to handle calls involving persons with developmental disabilities should possess a mixture of skills and information, along with specific knowledge about law enforcement and the criminal justice environment. In addition to being able to lead a discussion and encourage increased awareness, the trainer should display sensitivity to law enforcement officers training needs and personal biases.

The material was designed for one (1), eight (8) hour session of advanced law enforcement officer training in the state of Texas. It contains six major sections that are the result of state-wide fact finding research undertaken by the authors prior to the development of this material. While developmental disabilities are numerous by categories, the authors' findings from five community forums held in key Texas cities suggested that five major categories should be addressed. This material is organized by beginning with (1) an overview of DD, followed by sections on (2) mental retardation, (3) autism, (4) cerebral palsy, (5) epilepsy and (6) hearing impairments.

Confucius (551-479 B.C.), the Chinese philosopher gave words of wisdom that have stood the test of time in professional training. He said, *what I hear I forget, what I see I understand, what I do I remember.* This material contains elements of all three as it includes lecture material assisted with a generous number of transparencies to emphasize key points. In addition, it includes the use of three videos and a brief activity at the close of each of the six sessions.

Each section of this course is designed to meet the specific objectives of assisting with identification and communication with persons with developmental disabilities. The objectives are of two broad types. The first type refers to what officers should know about responding to persons with DD, and the second is to give them an opportunity to practice using the material just covered.

It is also suggested, that the instructor use one of several possible methods to acquaint participants with local and regional resources. One method may possibly be the use of a handout containing a list of agencies such as the nearest MHMR office and agencies such as the local chapter of United Cerebral Palsy, the Autism Society, etc. Another suggestion could be the use of a speaker such as a representative of the local community-based MHMR agency making a brief presentation during one of the sessions focusing their remarks on resources available in that community for persons with developmental disabilities. Lastly, a successful technique appears arranging for a few adults with life-long disabilities to visit the session in its closing momemts. This gives officers a close-up perspective that they might otherwise not ever experience.

Evaluation of this session will consist of two parts. We are asking for you to administer a 25 item true-false test prior to the beginning of the session and the identical instrument again at the close. Ask the participants to place their initial in the upper right hand corner for ease of matching instruments for comparison purposes. This will give the authors a chance to examine the effectiveness of the material. In addition, we are asking that the second quiz be accompanied by a one page questionnaire whereby participants can quickly and anonymously give their evaluation regarding the effectiveness of the session.

Suggested Schedule

The following schedule is suggested, assuming that the session is for eight hours.

8:00 - 8:10	Introduction and give first quiz.
8:10 - 8:20	Outside speaker giving overview of community resources
8:20 - 9:10	Lecture on **Developmental Disabilities**
9:10 - 9:25	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
9:25 - 9:35	Break
9:35 - 10:30	Lecture on **Mental Retardation**
10:30 - 10:45	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
10:45 - 10:55	Break
10:55 - 11:45	Lecture on **Autism**
11:45 - 12:00	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
12:00 - 1:00	Lunch Break
1:00 - 1:55	Lecture on **Cerebral Palsy**
1:55 - 2:10	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
2:10 - 2:20	Break
2:20 - 3:15	Lecture on **Epilepsy**
3:15 - 3:30	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
3:30 - 3:40	Break
3:40 - 4:30	Lecture on **Hearing Impairments**
4:30 - 4:45	Participants read corresponding section in **Trainee's Guide**, select a partner and engage in role playing activity.
4:45 - 5:00	Second quiz and course evaluation

The following videos are recommended:

Officer's Guide: Interacting with Disabled People

Making Contact: Communicating with Adults with Mental Retardation

Take Another Look - Police Response to Seizures and Epilepsy

It is also suggested that one outside speaker be used that can speak briefly on available community resources in the local community or county. Possible speakers may be from the local community-based MHMR agency, Goodwill Industries, local chapters of The Arc, Autism Society, Cerebral Palsy or a provider of specialized housing.

SENSITIZING POLICE OFFICERS TO PERSONS WITH DEVELOPMENTAL DISABILITIES

MODULE

Time Requirements of 8 Hours

Suggested Videos for this module:

- Making Contact: Communicating with Adults with Mental Retardation
- Officer's Guide: Interacting with Disabled People
- Take Another Look: Police Response to Seizures and Epilepsy

Suggested speakers from public/private agencies:

- Local community-based MHMR agency
- Goodwill Industries
- Housing Provider

TOPIC **FOUNDATIONS OF DEVELOPMENTAL DISABILITIES**

AT THE COMPLETION OF THIS SESSION, THE PARTICIPANT WILL BE ABLE TO:

Demonstrate a basic knowledge about developmental disabilities and why this topic is important to policing activities.

Understand the major classifications and identify persons with each of these life-long disabilities.

Understand basic rules of communications

Demonstrate knowledge of community resources that provide services to persons with DD.

Developmental Disabilities

Objectives

Performance Objective:

Given a subject with a developmental disability involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 6 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

Enabling Objectives:

1. **Demonstrate general knowledge of the unique factors of persons with any of the major categories of DD.**
2. **Role play with another participant with a DD in a simulated situation with emphasis on identification by category.**

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with a developmental disability. If someone has, ask them to tell of situation and how they knew the person had a developmental disability. What were the distinguishing characteristics? Then, present the following incident which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

As an officer, you arrive at a park in response to a call concerning the strange behavior of a young male. You encounter a male, approximately 30 years of age. Although the weather is quite warm, he is dressed in heavy clothes, an overcoat and a scarf. The man is following an older woman, asking her questions typical of those a child might ask. The woman is obviously bothered, and tries to brush him off, but he continues to asks questions, such as "have you seen my friend Bob?"

The officer observes the behavior, and questions the young man. His answers are simple, and stated in the manner of a child. His speech is slightly impaired. The young man explains, rather slowly, that he came to the park to play and has lost his friend. He also explains that he has been asking all the ladies in the park if they have seen his friend. You are asked to resolve the situation. Given the information from this class at this point, attempt to determine if a crime has been committed, identify if the person

has a life-long disability. Try to communicate with the person, soliciting basic information, and determine if there is a need for additional community resources. How do you resolve the incident?

Identification of a Person with DD

The Identification of a person with a developmental disability is not always easy. The majority of basic skills required hinge around discerning the classification of the disability (i.e., mental retardation, autism, cerebral palsy, epilepsy, hearing impaired) and the degree of the condition. The majority of efforts in identification will be explained as the material progresses through the specific disabling conditions. Extra emphasis will placed on mental retardation as it is the largest category.

---

overhead - Identification Tips - DD

Identification of a person with a developmental disability is not always easy, therefore some things for the officer to keep in mind include:

- Identification of a person with DD is most difficult when encountering someone who is mildly retarded.
- Persons with mild retardation are streetwise and are very clever at masking their limitations.
- Be familiar with the names of state schools, community based programs, special education programs, group homes, and respite programs in your area.
- Know local jargon relevant to group homes
- The person may not want their disability to be noticed.
- The person may be overwhelmed by police presence
- The person may be very upset at being detained and/or try to run away.

The officer should also observe for physical appearance:

- Is the person appropriately dressed for the season?
- Does the individual show any physical defect, that is, unusual physical structures?
- Does the individual appear uncomfortable with his/her body, or is there awkwardness of movement, poor motor coordination in walking, writing or other physical movements?
- Does the individual have a slow reaction to such stimuli as questioning?

- Inquire about education level.
- Ask if the person was in special education classes or vocational education.
- Obtain information from the person while conversing about his or her family and childhood history.
- Are there obvious speech problems?
- Is the person attentive?
- Does the person exhibit an inability to use abstract reasoning?
- Observe for social behavior
- Is the person easily frustrated?
- Does the person avoid questions concerning a disability?

Show video: *Officer's Guide: Interacting with Disabled People*

Background Information

Before this session goes further, everyone needs to familiarize themselves with a working knowledge of what constitutes a disability as related to an impairment and a handicap.

---

overhead - Definitions of Impairment ----

Impairment:

A loss of physical or mental functioning at the organ level.

Disability:

When the effect of the impairment is severe enough to inhibit functioning.

Handicap:

Obstructions imposed by society that inhibit the pursuit of independence.

Impairment is the correct term to use to define a deviation from normal, such as not being able to make a muscle move or not being able to control an unwanted movement. Impairment refers to a loss of physical or physiologic function at the organ level. Impairments exist in varying degrees and may or may not affect one's functioning. **Disability** is the term used to define a restriction in the ability to perform a normal daily activity that someone of the same age is able to perform. If the impairment is

so severe as to inhibit the person's ability to function, then we have a disability. **Handicap** is the term used to describe the condition of a person who, because of the disability, is unable to achieve a normal role in society appropriate to his or her age and environment. Obstructions in the pursuit of independence can arise when the person with a disability confronts public buildings that are not accessible to wheelchairs, or policies that limit participation. There are no handicapped persons, only handicapping conditions imposed by society. Stairsteps are handicaps for persons in a wheelchair.

---

overhead - The Impact of Chronic Conditions ---

- organ
- person
- family
- society

An impairment is at the organ level. In most cases, during the course of this study we are talking about the central nervous system. When the impairment is severe enough that it impacts the person, we have a disability. When a person's disability is severe enough, the person with the disability impacts the family. Every family that has raised a child with a developmental disability is permanently changed. Society is impacted when services are needed.

Basic DD Definition

---

overhead - DD Defined

A developmental disability is a severe chronic disability which is attributable to a mental or physical impairment or a combination of these factors. The onset occurs before the age of 22, and results in substantial functional limitations in three or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency. In addition, a developmental disability reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and, except that such term, when applied to infants and young children

means individuals from birth to age five, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

---

overhead - A Way to Understand DD

A good way to understand a DD is to think of it as:

- a condition that an individual may have had since birth or childhood,
- which during adulthood has prevented him or her from being fully independent, socially or vocationally,
- and which continues on into old age.

Why is this Training Important for Police Officers

Persons with life-long disabilities have experienced increased visibility in the community only in recent years. Multiple forces have converged to place emphasis on the needs of this subpopulation from the perspective of persons employed in the field of law enforcement.

The **first** major underlying reason for police to be informed about DD is that for the first time in our nation's history, we have escalating and very significant numbers of persons with DD who are entering the public school systems. Multiple reasons are thought to be involved in this phenomenon that includes higher rates of births from teenage mothers, mothers involved in substance abuse during the perinatal period, and improper care during the early years. Because of high-tech medical intervention, which includes the control of respiratory infections, large numbers of developmentally disabled persons are living beyond middle age. Previously death came earlier, usually because of respiratory complications. In summary, the number of persons with DD is increasing rather signficiantly.

A **second** factor has evolved as the result of social research. In previous decades, large numbers of persons with developmental disabilities were institutionalized in state schools and/or large intermediate care facilities for the mentally retarded (ICF/MRs). The results of continued research have indicated that the grouping of persons with like disabilities contributes nothing to either the quality or quantity of their social exchanges. Social exchange, regardless of the size of the facility, occurs between staff and client, not client to client. Furthermore as providers attempted to quantify quality of life issues, it was found that those with the more severe disabling conditions needed and benefited the most from integration into the community.

The **third** factor and an emerging social problem that is a precipitate of the community inclusion model is the growing number of persons with DD involved with law enforcement agencies and/or the criminal justice system. Not only are their numbers an extreme exaggeration to their naturally occurring percentages in society at large, countless lives have been lost in confrontational occurrences because the criminal justice system is lacking appropriate training involving situations where persons with DD are at the focal point. Providers of services to persons with DD agree that persons with DD are no more prone to criminal behavior than their non-DD counterparts (Reid, 1987).

The term *developmental disability* first appeared in federal legislation in 1970 and included three categories of individuals that had previously been treated as distinct populations - those with mental retardation, cerebral palsy and epilepsy. By 1975, individuals with autism and dyslexia were included among the populations considered developmentally disabled (Gelman, 1986). In 1978 the definition shifted from one focused on distinct diagnostic classifications or labeled disabilities to a more inclusive description that centered on *severe* and *chronic* disabilities. The word *severe* is generally implies the need for assistance in three of the important areas of life as shown below. *Chronic* generally implies that a condition is long-term in nature.

The word ***development*** must be distinguished from growth. Growth refers to an increase in physical size. Development has multiple connotations with the primary reference in this case to the normal developmental period of life. Implied in this case is also the implication of an increased control the person has over the physical body and the thought processes. It is in this area that the word takes on additional meaning when the normal evolutionary process for an individual is impeded and/or lacking to a noticeable degree. While the sequence of development is the same for all children, the rate of development varies from one person to another. An example depicting lagging development with a motor skill is when a child must learn to sit before it learns to walk. This involves the discarding of primitive reflex and replacing it with the development of a voluntary movement. Persons with developmental disorders involving a motor skill experience a persistence of involuntary reflexes beyond the usual age.

---

overhead - Four Types of Skills

The developmental period involves gaining mastery of four major types of skills:

- gross motor - such as walking, running, sitting
- fine motor - such as picking up small objects
- communication - capacities needed to understand others
- social - necessary for interacting with others.

Development of these skills occurs simultaneously to prepare a person to meet physical, social, linguistic and emotional demands. Gross motor skills involve the use of large muscles in such activities as sitting, running, walking, and other activities. Fine motor or adaptive skills involve the use of small muscles such as in the fingers and hands, and include manipulative skills, such as those used for feeding and dressing, skills that are necessary to interact effectively with the environment.

Communication skills are the capacities needed to understand others and express oneself. Communication skills are both verbal and nonverbal and are used in understanding both simple and complex instructions. This area encompasses the development of receptive language, which is the ability to receive and process information, and to understand its meaning. Communication also includes expressive language or the ability to transmit information. Social skills are the skills necessary to interact with others. Adults with developmental disabilities, for a variety of causes, failed to master control of their lives because the development of these skills did not progress. A developmental disability refers to any disability appearing early in life that impedes on the child's development. It is important to remember that it is not the clinical diagnoses that is critical, rather one's functional ability.

Because (as shown above) of their severe and chronic impairments, individuals with DD are more vulnerable and less able to reach an independent level of existence as compared to their non-disabled peers. The four skills listed are sufficiently acquired during the early years, which is not the case for persons with DD. Families of persons with DD bear the major responsibility for providing or arranging for care and services. The extent to which persons with DD reach their full potential in education, independent living and employment reflects the persistence and resourcefulness of families in advocating on behalf of their family members with disabilities.

In the United States, there are approximately 40 million persons with disabilities that are significant enough to limit or restrict functioning to some degree. This figure represents 15

percent of the general population. The onset of a disabling condition can occur at any point, prior to or during the developmental years, throughout mid-life and in the retirement years. This material is about the unique characteristics of persons whose onset is perinatal or during the first 22 years of life. This is generally thought to be about five percent of the general population.

Categories of Developmental Disabilities

---

overhead - DD Encompasses a Variety of Conditions

- mental retardation
- autism
- cerebral palsy
- epilepsy
- deafness
- blindness
- orthopedic impairments
- learning disabilities
- other neurological/sensory impairments

Prevalent developmental disabilities include mental retardation, autism, cerebral palsy, epilepsy, (thus the acronym MACE) and other neurological impairments. Developmental disabilities encompass a variety of other conditions that include blindness, deafness, orthopedic impairments, learning disabilities and other neurological/sensory impairments. This training session will examine the unique characteristics of five categories most likely to be confronting the law enforcement officer: mental retardation, autism, cerebral palsy, epilepsy and hearing impaired. All of these conditions can manifest in varying degrees from very mild to extremely severe.

Certain ancient historical concepts of developmental disabilities have been preserved through paintings, sculptures, mosaics and the like. Nearly 4,000 years ago it was common to use dwarfs as entertainers in royal courts, a practice that lasted through the seventeenth century. Naturally, there is no clear record of how many such entertainers had overlapping disabling conditions but, given what is known about genetic influence on dwarfism, and dwarfism itself, it is reasonable to assume that some were at a minimum mentally retarded.

A societal shift in western thinking about persons with DD began to occur about 1700 as the result of viewing them through

a scientific concept as opposed to a supernatural one. While well intentioned professionals had widely varying views about persons with DD, they were unanimous in their belief that they could best be served through segregated living arrangements. While an approach of *dividing and conqueroring* seems archaic, by bringing the majority of the vast assortment of persons with DD into common living arrangements, specialists began to realize the vast differences that existed among those labeled mentally retarded.

Over the past 25 years, services to persons with DD have been in a state of flux. Since the 1970s, experts have been educated and trained to provide highly specialized services to individuals residing in segregated community facilities and/or working and pursuing activities in segregated community sites and programs. The community placement model was a reaction to the earlier custodial mode of treatment that eventually invited litigation (1960s and 1970s) in response to the deplorable standards of care existing in public institutions. And now, in the 1990s, experts recognize best practices as those that offer supports and assistance to participants within inclusive communities.

Inclusive community, or more simply put, the community membership paradigm, is not synonymous with community placement. Community placement was the logical outgrowth of the deinstitutionalization movement of the 1960s and was based on a developmental paradigm. The underlying assumption of this model was that all persons, regardless of their level of disability could learn and grow. Part of this earlier reasoning was that development took place in separate settings within a community that could not be accessed until skills were perfected. That is, specialized services such as sheltered workshops, group homes and rehabilitation services were established to prepare the participant for eventual integration into less restrictive environments. The basic orientation of specialized services was to move the person to a specialized environment where problems could be worked on and skills could be developed. The assumption was made that once people had achieved a higher level of functioning they could move on to a less restrictive setting, typically to a group home or other community facility. To reach a higher level of functioning, skills were taught without regard to the natural context in which those skills would be practiced. Across time, leaders in the field of DD developed suspicions that separate and specialized settings may have become just another institutionalized system. Few individuals left the sheltered workplace for jobs in the integrated world and fewer yet were found in normalized social settings that included semi or independent housing.

The road from institutionalization to community inclusion for persons with any of the cluster of developmental disabilities (DD) has been long, complex and fraught with unforeseen difficulties. One such problem is the percentage of persons with DD confronting the criminal justice system which is frequently reported as approaching seven times the corresponding number in the general population. At the same time, most authorities argue that those with life-long disabilities are no more likely to commit crimes than the non-disabled. In summary, the majority of persons who were once institutionalized are now living in the community and receiving supports as needed.

Community inclusion implies that persons with DD are both **in** and **of** the community. As citizens they are entitled to the same rights and privileges under the law as the non-disabled. Currently, in most states, criminal justice personnel receive adequate training on mental illness, yet virtually no training about the characteristics of persons with DD. This absence of training has led to undue hardships for the DD community in experiencing equal treatment within the criminal justice system.

The emerging paradigm, calling for functional development while in the community rather than as a precedent to community inclusion, is based on the assumption that persons with disabilities are more like than unlike the rest of the population. Therefore, work skills are acquired at a job in the community, living skills are developed in the individual's own residence and social skills are learned as the person interacts in social settings within the community. This model has a logical sequence as mainstreaming or community inclusion, and strongly suggests that, as a consequence, larger numbers of persons with DD will be confronting the criminal justice system.

Recently there has been a growing awareness of the discrimination that persons with life-long disabilities face and a recognition that these people have a right to be treated with equal respect and consideration by all members of society. Equal treatment, particularly from a legal aspect, has often been denied because they have not mastered basic communication skills, they are denied linguistic access to the law and its processes, that is, they cannot communicate successfully with those who represent the law.

Prevalence Rates of DD

The prevalence rate of persons in the general population varies by source, by country and by type of measurement. It is generally thought that, when cumulatively considering all types of DD, approximately 5 percent of the general population is involved. Authorities (too numerous to reference) seem to be in

agreement that approximately three percent of the population have some degree of mental retardation. Further, most sources report that approximately 90 percent of those with mental retardation as their primary disabling condition test in the range of **mild** retardation. The primary contributor, in excess of 80 percent of the entire number with mental retardation, is environmental conditions, such as the living environment.

The exact number is also very nebulous as many cases are never reported and many persons have overlapping conditions. The number is also subject to differences depending on whether or not persons with learning difficulties are included. That category tends to be specific to educational environments. To qualify for Medicaid assistance in Texas, an individual must have an IQ of 69 or below (TPCDD, 1991). This is the generally accepted level, determined by standardized tests, to be the cut-off point with a score of 100 considered average.

In the past there has been a lack of awareness and sensitivity among the general public with respect to the words used to describe people with disabilities. Over the past 20 years, however, an increasing amount of attention has been paid to such language, and recently a great deal of attention has been given to issues of education, employment and public access for individuals with disabilities. Because of this evolving awareness and respect, it is no longer acceptable to refer to individuals by their disability, such as the *spastic* or the *epileptic*. The current acceptable terminology stresses the individual person first and then the disability second. Person first language acknowledges that there is more to the person than merely the disabling condition. Other terms that are now used and contribute to a more enlightened view is the usage of such terms as *mentally challenged* rather than mentally retarded.

The definitional issues for police officers need to be understood from another perspective. Our interest in this material is not only the developmentally disabled but the offender with DD. An offender is one who commits an act or offense which is against the law. The criminal justice system by definition must concern itself not only with the physical act or violation but also with the mental state of the alleged person who broke the law. Criminal actions are defined by legislatures to provide punishment for those who commit specific acts in the presence of certain underlying circumstances while possessing certain states of mind. The state of mind is an integral element of a criminal act. In order to be found guilty of a crime, all three elements must be present: the act, the underlying circumstances and that the accused acted knowingly. In other words, the accused must have acted

purposely, knowingly, recklessly and negligently in order to be held accountable for an offense. It is for this reason that identification is a key factor in the processing of a person suspected of committing a crime that possibly has a life-long disability.

Once it has been determined that the accused person has a developmental disability, every effort must be made to determine whether the individual's mental impairment(s) and functional limitations rule against his/her coming to trial. An individual whose mental condition is such that he/she lacks the capacity to understand the nature and object of the proceedings against him/her, or to consult with an attorney, and to assist in preparing his/her defense may not be subjected to a criminal trial. Conviction of an accused who is mentally incompetent, violates their due process of law. In addition, these persons are likely to be targets of victimization by other prisoners.

Offenders with DD

The number of persons with DD who commit crimes cannot be ascertained with much confidence. Obviously, it is impossible to know if a crime was committed by a person with DD unless the perpetrator is apprehended, tried and convicted. Frequently the apprehended person is not identified as having a life-long disability by the police, the jails, the courts or by his/her attorney. It is not until the defendant is convicted and sentenced to prison that testing to identify the existence of DD is conducted.

Some authorities believe that the rates of mental retardation as a category are often overstated due to persons likely being frightened, hostile, non-cooperative, having emotional illnesses or symptoms of other conditions at the time they are being tested. Testing is usually done immediately after entering prison and the person has not stabilized or adapted to the new environment.

The following characteristics are known about federal and state prisoners with DD (DHHS, 1991).

---

overhead - Characteristics of Prisoners with DD

- The majority are male
- The majority are from minority groups. In Texas 8 out of 10 are either Black or Hispanic. This is probably due to economic considerations.
- Many defendants come from broken or dysfunctional families and have little community support.

- Often they develop low self-esteem from performing poorly in school, along with a low level of expectation from family members.
- The majority have mild mental retardation.
- Some carry a dual diagnosis of DD along with mental illness
- Some inmates have additional disabling conditions.

The frequent claim that offenders with DD tend to commit serious crimes is misleading. The above data (overhead) is based on data from federal and state prisons which are likely to receive inmates who commit serious crimes. In reality, the overwhelming majority of offenses committed by these persons are misdemeanors, less serious felonies and public disturbances.

With regard to offenses committed by inmates with DD, crimes of burglary and breaking and entering are the categories that occur the most frequently (Santamour & West, 1982). Homicide ranks as the second highest category of offenses, yet at a far reduced rate compared to the non-disabled prison population. By far the majority of crimes committed are lesser offenses considered petty and generally do not lead to incarceration.

People with mild mental retardation tend to be followers, easily manipulated and often used by others with more intelligence and/or experience. As examples, they may act as lookouts, transport drugs or other contraband, carry a forged check into a bank or attempt to sell merchandise stolen by others. Studies show that persons with DD are not only more likely to be arrested, but also to be convicted and sentenced than are other offenders. Factors for the high conviction rate of persons with DD can be attributed to the primary contact with police officers. Persons with DD are usually the last persons to leave the scene of the crime and are most likely to take responsibility for a crime that they have not committed.

One possible reason that the percentage of persons with DD in prisons is out of proportion to the percentage in the non-prison population is due to probation policies. Probation is more commonly granted to individuals with higher intelligence and greater educational achievement (Santamour & West, 1982). Persons with DD are generally undereducated and underskilled. Work histories are also a very important consideration, and these persons tend not to have a work history. Therefore, they tend to be considered as poor candidates for probation. Probation is arbitrarily denied on the basis of an unsubstantiated belief in the ability of the person with DD to handle probation. There have been no studies to confirm this falsehood.

Suggested Activity Using the Trainee's Guide:

1. Check your own general knowledge about **developmental disabilities** on page 2 and 3, answer the questions on page 3. Compare your answers with the answers on the following page.
2. Role-Playing Activity: Working as a pair, with one partner role playing the part of the officer and the other team member acting the role of the suspect.

Mental Retardation

Objectives

Performance Objective:

Given a subject with mental retardation involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 12 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

Enabling Objectives:

1. **Demonstrate general knowledge of the unique factors of persons with mental retardation.**
2. **Role play with another participant with mental retardation in a simulated situation with emphasis on identification and communication.**

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with mental retardation. If someone has, ask them to tell of situation and how they knew the person had mental retardation? What were the distinguishing characteristics? Then, present the following scenario which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

As an on-duty officer, you are responding to a call at a shopping mall. The store manager of the toy store believes that a middle-aged man has just engaged in shop-lifting and is still in the store. You are told that the suspect has put a small piece of

merchandise in his pocket. You approach the suspect, introduce yourself and ask initial questions. The suspect has difficulty answering your questions and begins crying at a low-intensity. You observe that he has a limited vocabulary which suggests to you that his condition is mental retardation. Proceed with the interview while utilizing some of the performance tasks that you just learned about. If you detect mental retardation, how will you resolve the incident.

Identification of a Person with Mental Retardation

Identification of a person with M-R is not always easy particularly when encountering someone who is mildly retarded. This is because the majority are in the *mild* range, therefore a higher degree of interaction between the police officer and the person is required in comparison to trying to determine mental illness. In the majority of cases persons with M-R cannot be identified by physical characteristics.

The identification is often delayed until after the trial and sentencing. This delay may prevent the prosecution, the defense and the judge and jury from appropriately considering the effects of mental retardation such as determining competence and criminal responsibility. Also, persons with mild retardation are streetwise and are very clever at masking their limitations. The following are some general areas to consider in the identification process:

---

overhead - Physical Appearance

Physical appearance

- Is the individual appropriately dressed for the season?
- Does the individual show any physical defect, that is, unusual physical structures?
- Does the individual appear uncomfortable with his or her body or is there awkwardness of movement, poor motor coordination in walking, writing or other physical movements?
- Does the individual have a slow reaction to such stimuli as questioning?

---

overhead - Educational History

Educational History

- Check available records
- When asking for identification–ask for cards issued by city transportation agencies as these ID's sometimes disclose physical or mental impairments.
- Obtain information from the person while conversing about his or her family and childhood history.
- Is the individual in the proper school grade for his or her age? Two or more grades behind in school is evidence that this may be a retarded person.
- Is the individual in a special education class or vocational class?

---

overhead - Speech/Language Problems

Speech/Language Problems

- Does the person have any obvious speech defects?
- Does the person understand the questions?
- Are there any signs of deafness?
- Is the person unable to provide appropriate answers?
- Does the person offer parroted responses?
- Does the person understand his/her Miranda rights? Is the person able to explain them in his/her own words?
- Is the person attentive?
- Does the person exhibit an inability to use abstract reasoning?
- Does the person have a limited vocabulary or limited grammatical skills.
- Does the person have difficulty describing facts or details of the offense?

---

overhead - Social Behaviors

Social Behaviors

- Does the person associate with children or younger persons?
- Does the person seem to want to please?
- Does the person crowd personal space when interacting with others? Are they oblivious to their surroundings?

- Does the person behave in a manner that is inappropriate for his/her age? They often engage in a low degree of crying in a crisis situation. Also they tend to pickup cues from what someone else is doing and mirror the action.
- Is the person easily persuaded or influenced by others?
- Does the person have an advocate, who assumes responsibility or provides help to the person with mental retardation in certain situations? Note: Sometimes he or she may act solitary, but this does not imply unlikable or unfriendly behavior.
- Is the person easily frustrated? They can react aggressively as the result of their perception of fear, which is why officers should use a conciliatory posture. Persons with M-R read a great deal into posture.
- Does the person avoid questions concerning a disability (for example, questions concerning special education and vocational training), remain silent or take a long pause before answering?

---

overhead - Performance Tasks

Performance Tasks – Try to keep the tasks within the context of the situation. Ask the person to:

- Identify himself/herself by name.
- Read and write (read a few sentences in their primary language out of a newspaper or magazine; read a street sign; write their first and last name, address, including the zip code and telephone number)
- Use the telephone.
- Identify his/her number in the telephone book.
- Describe the appearance of someone they know.
- Give directions to their home.
- Name the first four months of the year.
- Repeat five numbers backwards, do not explain backwards.
- Tell time on a regular watch or clock; usually they can not tell time to the minute, neither are they accurate in recalling time.
- Count to 100 by 10's or 5's.
- Define some words, i.e., sympathy, deceased, pharmacy, etc.
- Tell you the date, time, month, year and city.

- Make change. How many dimes are in a dollar? How many nickels in a dollar? etc.
- Does the person understand directions?
- Does he/she use public transportation?
- Does he/she have the ability or understand his or her rights upon arrest–that is, the Miranda warnings?

It is important that the officer be sensitive to the dignity of the person. Testing and asking information can be done without making the person aware that he/she is being tested. If the person is unable to do any of the above mentioned, the person will find a way to avoid doing the task (Santamour, 1989). The officer should be acutely aware that the person's failure to succeed in one of these tasks in front of an acquaintance (the professional or a friend) will cost him or her a considerable amount of self-respect. It may cause humiliation or could likely force them into a set of behaviors easily interpreted as a lack of motivation–or maybe even aggression towards authority or the system (Santamour, 1989).

---

overhead - Criminal History

- Check records and look for evidence that the person has been involved in criminal activity as a follower.
- Has the individual become involved in illegal activity to gain acceptance from others?
- Is the person noticeably older than the other persons involved? Was the individual with younger adolescents at the time of his or her arrest?
- Was the individual the initiator of criminal activity? Was the person a follower? Most often a person with a developmental disability is a follower, not a leader.
- Did the individual show a greater likelihood of confessing to the crime that he or she was charged with?
- Did the person remain at the scene of the crime while others ran? Did the person seem confused about whether he or she had been involved in something illegal?

---

overhead - Officer Makes a Determination of M-R

If the officer determines that the person is retarded, what should be done?

- Notify as soon as possible the person's parents, legal guardians or those who provide care for the person.
- If the above is not possible, the officer should attempt to contact a mental retardation agency for assistance.
- If the crime was fairly minor, always try to reach a disposition not involving the criminal justice system. However, the parent/guardian/house counselor should be made aware of the incident and advised to guard against a similar occurrence.

Identification Summary

In general, persons with M-R will provide inferior responses and those responses will be a function of his/her level of retardation. While interviewing the person, the officer should be aware of the person's reactions to the questions. Nonverbal behavior or body language often providers as much information as the answer itself. Avoiding questions regarding his/her background, such as special schooling or vocational training, large gaps in answers or even silence may all be an indication of retardation. Rephrasing the question once or twice might help get an answer. Obvious reluctance to discuss what might appear to be a simple matter, such as education, is a valuable clue in itself and should not require a constant attempt to help gain a satisfactory answer.

Mental Retardation Defined

---

overhead - Mental Retardation Defined

Mental retardation (M-R) refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work (AAMR, 1992).

Mental retardation is further characterized as a fundamental difficulty in learning and performing certain daily life skills that involve the realms of conceptual, practical and social intelligence. These three areas are specifically affected in M-R whereas other personal capabilities such as health and temperament may not be. A score of 70 or below indicates subaverage intellectual functioning.

A less complex and less wordy definition of this the largest category of developmental disabilities is:

---

overhead - Working Definition

- **Significant below average intellectual functioning**
- **Deficits in adaptive behavioral functioning**
- **Manifests before the age of 18**

The term *intellectual functioning* is determined by an intelligence quotient (I.Q.) obtained by scores from standardized measures (tests) of general intelligence. The word *quotient* has long meant the number resulting from the division of one number by another. In this case quotient, or ratio, is mental age divided by chronological age times 100 (I.Q. = MA/CA x 100). Thus if a person's mental age corresponds to his/her chronological age, as determined by standardized tests, the ratio or quotient would be one (1) times 100. In this manner, an I.Q. score of 100 became the norm and the mid-point of the range between 90 and 110.

Below Average Intellectual Functioning

---

overhead - Classification of Intelligence

The graphic illustration places approximately 50 percent of all persons in the ***normal*** range which requires scores from 90 to 110. Immediately on either side of normal is another 15 percent with those in the range of 80-90 considered ***dull normal***, and those from 110-120 are considered ***bright normal***. The second range out from 100 reflects I.Q. scores from 70-80, labeled ***border line***; ***superior*** scores ranging from 120-130. By totaling the percentages under the curve at this point we have 94 percent. The remaining six percent is equally divided: three percent at the low end which are ***retarded*** and three percent at the upper end which are ***very superior***. This section is about those at the lower end on the bell shaped curve which show significant sub-average general intellectual functioning.

Prevalence Rate of M-R

---

overhead - Division of 3% with M-R

For many decades it has generally been recognized that three (3) percent of the general population has an intelligence score that falls some degree below average. One of the important

facts to keep in mind is that the rate of persons that are incarcerated is far out of proportion to their numbers in the general population. Reports vary from 10 percent to 75 percent with many professionals believing that as much as 30 percent of the prison population is M-R.

Of the retarded, at least 85 to 90 percent are in the educable *mild* range with I.Q. scores in the range of 50-69 (about 2.5% of the general population). Of the remaining, about four-tenths of one percent (.4%) is in the range between 30-49 and labeled *moderate*. One tenth of one percent (.1%) is considered *severe* or below an IQ of 30. Because all individuals are unique and have different strengths as well as weaknesses, a diagnosis of mental retardation does not imply that all persons in a given range will exhibit equal functional capacities. These levels reflect the degree of difficulty a person has in learning.

---

overhead - Functioning Potential of Persons with M-R

It is important to remember about those in the following ranges that they tend not to be violent or substance abusers, and that MR is not a communicable disease.

- Persons who are mildly/moderately retarded:
  - Differ from non-retarded persons only in their rate and degree of intellectual development.
  - Should have access to and participate in specialized and generic services in the community.
  - Can live satisfying and productive lives in the community
  - Usually lose their identity as retarded when employed and involved in community life.
- Persons who are severely retarded:
  - Have a substantially impaired ability to learn
  - Frequently have disabilities in addition to mental retardation.
  - Have poor judgment and may be subject to exploitation by others.

Person in the latter category would likely require supervision at home or in employment. If you encounter a person who is severely or profoundly retarded, you should offer some level of protective assistance. Their needs are exactly the same as those of the non-retarded - to be loved, to be important, to be

someone, to feel worthwhile, and to have a sense of worth and human dignity.

Adaptive Behavioral Functioning

The second criteria necessary in the determination of mental retardation is the presence of limitations in the area of *adaptive behavioral functioning*. Limitations of this type must exist concurrently with below average intellectual functioning and generally occur within the context of community environments typical of the person's age peers. In addition, these deficits generally are an indicator of the person's individualized needs for supports. Adaptive behavioral functioning refers to the behaviors that a person demonstrates in his or her effectiveness in adapting to the environment.

The limitations in adaptive skills are more closely related to the intellectual limitation than to some other circumstances such as cultural diversity or sensory limitation. Evidence of these limitations is necessary because intellectual functioning alone is insufficient for a diagnosis of mental retardation. The AAMR's criteria states that a significant disability in two or more adaptive skill areas has to exist. The 10 areas of skills are as follows (AAMR, 1992):

---

overhead - Adaptive Skills

- Communication - comprehending what has been said and the ability to express oneself verbally or non-verbally such as with gestures or through writing. Conversations may appear mundane as much of what the person with M-R expresses is with language that is child-like which is a reflection of their developmental age.
- Self-Care - possesses skills such as eating, dressing, toilet care, grooming, practicing hygiene and other basic needs.
- Home Living - possesses skills such as cooking, budgeting, home care, house keeping, house chores and contacts with neighbors.
- Social Skills - has use of such skills as fostering friendships, appropriate sexual behavior, typical social exchanges with others.
- Community Use - includes the appropriate use of community services, knowing how to travel in the community and return home.

- Self-Direction - includes being able to following scheduled activities, learning about the environment where he/she lives, making choices, assertiveness and completing tasks.
- Health and Safety - involves a basic understanding of a healthy lifestyle, doing prevention, seeking treatment, following safety rules and being responsible for their own health.
- Functional Academics - possesses the ability to apply the skills that he/she learns such as writing or the use of basic math.
- Leisure - involves doing recreational activities that are self-generated or part of a group.
- Work - can demonstrate the ability to hold a job, improve work related skills and interact with co-workers.

Manifests before age 18

The third criteria of M-R is that the condition must manifest before the person is 18 years of age. This is a deviation from the criteria as set forth in the basic definition of a developmental disability. This age is used as it approximates the age when persons in American society typically assume adult roles as the result of completing basic public secondary education.

Police Situations

---

overhead - Police Situations with Persons with M-R

Police officers come in contact with persons with mental retardation in four different types of situations:

- **Victim of a crime** - Persons with M-R are easily taken advantage of which lends itself to being open to suggestions. He/She may be lured into a non-observable area and then robbed or beaten simply because they could not recognize the danger of the situation. Frequently these persons are subject to verbal, physical or sexual abuse. In addition, these persons frequently will not know when he/she has been victimized. It may be necessary for an officer to explain to a victim with M-R what has happened in order to secure relevant information for a case.
- **Witness** - Persons with M-R can serve as effective witnesses, however, extra patience may be required. The officer should remember that a person with M-R may have a shorter attention span and have problems with abstract thinking.

- **Offender** - Common misconceptions would lead law enforcement personnel to believe that the population that is mentally retarded commits the majority of violent felony crimes. The reality is that the overwhelming majority of offenses committed by these persons are misdemeanors, less serious felonies and public disturbances. Studies show that not only are persons with M-R more likely to be arrested , but also to be convicted and sentenced more than other offenders. Estimates of those found guilty and sentenced run as high as 30 percent (Poelvoorde, 1991). Likewise, persons with M-R may very innocently be involved in a crime thinking that they are doing someone a favor such as transporting illegal substances.

It has been found that many delinquent acts committed by persons who are mentally retarded are due to their level of social and behavioral insight. Also, individuals with M-R are sometimes easily led and intimidated, and may have a desire to please the questioner, which makes them vulnerable when questioned by authorities anxious to resolve a crime.

When encountering a suspect with M-R one should explore every possibility of keeping the suspect out of the criminal justice system. As mentioned earlier, the officer and the entire criminal justice system by definition must concern itself not only with the physical act or violation but also with the mental state of the alleged person who broke the law. Criminal actions are defined by legislatures to provide punishment for those who commit specific acts in the presence of certain underlying circumstances while possessing certain states of mind. The state of mind is an integral element of a criminal act. In order to be found guilty of a crime, all three elements must be present: the act, the underlying circumstances and that the accused acted knowingly. In other words, the accused must have acted purposely, knowingly, recklessly and negligently in order to be held accountable for an offense.

Frequently the suspect may not understand his/her civil rights including the Miranda warning. This fundamental American right potentially poses particular problems when it is only partially comprehended or not understood at all. This is also important as the offender may be so frightened by the police that he/she may be fearful of invoking the protections that are identified, particularly if they are not well understood. In consequence, offenders with M-R may confess to crimes, or provide other information when it is not in their best interest to do so. In some cases it has been observed at the conference that persons with M-R

confess to a crime even though they did not commit it (DHHS, 1991). Further, the information they provide is sometimes of doubtful accuracy, not because of an intent to deceive, but because of limited ability to observe, comprehend and express themselves. Since prosecution cases are often based on confessions and information given by accused persons, a failure to utilize the rights provided by the Miranda warning can place offenders with M-R at a severe disadvantage resulting in a miscarriage of justice.

- **General police contacts** - In all situations, it is extremely important for the officer to proceed in the following manner when encountering a person with M-R.
  - Make the person feel safe and comfortable in the environment.
  - Assure the person that you are a friend, and try to calm him/her if agitated.
  - Use a normal tone of voice, average speech and a non-threatening attitude; this will yield responses to your questions.
  - Use patience and proceed slowly to be sure the person understands your questions and his/her rights. This is particularly important as generally the police have no problems with persons with M-R and the typical encounter will require the police to be a helper rather than an apprehender.

Communicating with Persons with M-R

Suggest inserting the video, *Making Contact: Communicating with Adults with Mental Retardation.*

Note: This video was done in a medical-type (non-criminal justice) setting and participants should be so informed. The authors of this material believe that it makes some excellent points regarding communication with persons with M-R. The following are the key points that are worthy of summarizing at the completion of this section:

- **Leveling - the officer and the person at the same eye level assists in establishing trust.**
- **Eliminate as many distractions as possible**
- **Remove others that might be a distraction - this must be a direct conversation between the two of you.**
- **Use open-ended simple statements and do not supply answers.**

- **Provide feedback and be sincere as the person picks-up on this and will tend to respond in an open manner.**

The person with M-R presents unique problems to the officer, especially with respect to communication. Part of the dilemma, particularly where an obvious crime has been committed brings the question of what takes precedence. Is the individual to be viewed as an offender with M-R; or a person with M-R who has committed a possible offense? This material takes the position that probably he/she should be viewed as a special offender. In addition, just as there are varying degrees of M-R, so are there varying degrees of communication problems. In some instances very little assistance will be needed.

It is not the intent of this material to detract from the fact that law enforcement personnel, by virtue of his/her responsibilities as prescribed by law has as their first priority that of the protection of the interests of society. Recognizing that there are various levels of competency, yet each act must be dealt with individually. Regardless, that involves gathering information, much of which involves communication. This material seeks to develop a sensitivity to the communication demands of a situation where a person with M-R is involved. Verbal communication should be emphasized only after any confrontation is stabilized which is the officer's foremost concern. It is after stabilization occurs that a critical analysis can incorporate the concepts used here.

Communication has little value if the sender is the only one who understands what was said. Because what we speak and hear shapes how we think about the world and how we relate to it, our language can be thought of as either a *battleground* or a *meeting place*. In operational terms this means expanding and detailing the meanings that a victim, suspect or witness might need to make rather than restricting or controlling possible or expected meanings. Restriction and control of meaning can occur if you do not recognize when a person has not understood what you are saying. This can also occur by failing to recognize that a person, especially with M-R might need an individual style of help or support in order to supply the information you need.

In this context, the officer is cautioned to remember:

- Persons with M-R are first and foremost people.
- Persons with M-R are more like the officer than unlike them.

- They cannot be required to forego any rights or human considerations afforded to everyone else.
- Treat adults as adults, do not treat adults who have mental retardation as children. Give the same amount of respect to a person with M-R that you would give to any other person.
- They are subject to the same influences as the non-retarded.
- They are sensitive to other's speech and actions and will respond in the manner in which they are treated.
- They represent a wide range of descriptors and abilities.
- They should be approached in a positive manner, not be belittled.
- Do not assume that someone with a developmental disability is totally incapable of understanding or communicating.
- Persons with M-R do not like being called retarded or even have the word retardation used in reference to their disability. Use the phrase person with a disability.
- The person may not want their disability to be noticed.
- The person may be overwhelmed by police presence.
- The person may be very upset at being detained and/or try to run away.
- The person may have difficulty describing facts or details of offense.
- Be aware of a retarded person's reluctance to discuss the matter.
- Be aware of a retarded person's attempts to please others.
- The person usually understands more than he/she can indicate.

---

overhead - Officer's Attitude

- Use an average attitude.
- Use a non-threatening attitude.
- Be patient.
- Take time giving or asking for information.
- Use firm and calm persistence if the person fails to comply or acts aggressive.

The officer's success requires that they recognize that their contribution to the conversation is the key determinate. Persons with M-R will respond better if the officer remembers that their mental age is less than their chronological age, therefore persons with M-R have a much reduced capacity to understand anything abstract. The officer should break information needs into small chunks and use simpler language.

---

overhead - Tips When Communicating

- When possible, arrange for a quiet and private setting.
  - This will help the person relax, enable the officer to interview the person, and reduce any embarrassment the person might feel in a more public setting.
  - Try to calm the person, make the person feel safe and comfortable in the environment, and assure the person that you are a friend.
  - Avoid any rapid-fire questions - this serves to intimidate or unnerve the person
- Speak directly to the person
  - Speak slowly and clearly.
  - Use simple language and vocabulary.
  - Keep sentences short.
  - Break complicated series of instructions or information into smaller parts.
  - If possible use visual aids, picture symbols, diagrams and actions to help convey meaning.
  - Use concrete terms. Abstract ideas may confuse the person with disability.

---

overhead - Additional Communication Tips

- Repeat and rephrase questions once or twice.
- Do not badger the person, it might result in uncooperative behavior.
- Ask for concrete descriptions: colors, clothing, etc.
- Avoid confusing questions about reasons for behavior.
- Do not ask leading questions.
- Ask open-ended questions.

- Avoid yes and no questions.
- Be aware of the person's reactions to the questions.
- Listen carefully to the content of the answer.

Everyone has the right to be heard and responded to in a language they understand. It is a challenge of the entire criminal justice system to make that right a reality for people with M-R.

Community Resources for Persons with M-R

Texas has 31 community-based MHMR centers with M-R components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource when needed. In addition many communities will have a local chapter of the Association of Retarded Citizens (ARC). The address of the national office is as follows:

The Arc
500 East Border St., Suite 300
Arlington, TX 79010
1-817-261-6003
1-800-433-5255

Suggested Activity using the Learner's Guide:

1. Check your own general knowledge about **mental retardation** on page 8, and answer the self-check questions on page 9. Compare your answers with the answers on page 11.
2. Role-Playing Activity: Working as a pair, with one partner role playing the part of the officer and the other team member acting the role of the suspect.

Autism

Objectives

Performance Objective:

Given a subject with autism involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 18 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

Enabling Objectives:

1. **Demonstrate general knowledge of the unique factors of persons with autism.**
2. **Role play with another participant with autism in a simulated situation with emphasis on identification and communication.**

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with autism. If someone has, ask them to tell of situation and how they knew the person had autism. What were the distinguishing characteristics? Then, present the following incident which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

It is a weekend morning and you, as an officer of duty, are asked to respond to a 911 call. Upon arriving at the address, you are met at the door by the attendant of a group home housing persons with developmental disabilities. The female attendant tells you that one of the respite residents (there only for an extended weekend), is behaving in a bizarre manner. She states that she only works part-time and that this young man has never been here before. She believes that the tantrum like mannerisms began when she tuned the radio to some hard-rock music. The music is blaring in the background, and it is further observed that there is a broken vase on the floor.

Based on what you have just learned, how would you attempt to assist the attendant? What category of developmental disability do you suspect this to be, and what contributed to the young man having a tantrum?

Identification of Persons with Autism

---

overhead - Identification of a Person with Autism

General things for police officers to keep in mind as persons with autism exhibit some or all of these symptoms:

- Persons with autism may have sensory impairments.
- Persons with autism may have uneven patterns of intellectual functioning (70% of persons with autism have varying degrees of mental retardation).
- Persons with autism may engage in repetitive behavior.
- Persons with autism like a fixed routine.
- Persons with autism may have marked restriction of activity and interests.
- Persons with autism do not like to be touched.

In criminal justice situations the person with autism:

- may not understand his/her rights,
- may have difficulty remembering facts or details of offenses,
- may become anxious in new situations,
- may not understand consequences of their actions.

Autism is a developmental disorder characterized by three closely related conditions: impaired social relating and reciprocity, abnormal language and communication development and a restricted behavioral repertoire that may include repetitive activities and routines (Stone & Ousley, 1996). Thus autism is a syndrome or a cluster of conditions. The condition is usually diagnosed before a child reaches three years of age.

---

overhead - Characteristics of Autism

- impaired social relations
- abnormal language & communication development
- restricted set of behavioral skills

Impaired Social Behavior

---

overhead - Social Behavior

- Lack of awareness of social rules
- Lack of awareness of or attention to others–staring past things, seemingly at someone else or staring into space or

through things and a stand-offish manner

- Poor, unusual or lack of eye contact
- Inappropriate laughing or crying (used as form of releasing anxiety, fear, and tension)
- Flat facial response - emotional response does not match situation
- Trouble with transitions and interruptions
- Resists change in schedule or environment
- Ritualistic behaviors
- Slow to predict consequences
- No fear of real dangers
- Extreme distress for no discernable reason (e.g., crying tantrums)
- Difficulty mixing with others
- Inappropriate attachments to objects
- Deliberate soiling
- Uneven gross/fine motor skills
- Marked physical over-activity or passivity

Impaired Language Skills

---

overhead - Communication and Language

- May be non-verbal or have very limited verbal abilities
- May appear deaf; may not respond to verbal cues
- May repeat words or phrases in place of normal communications
- May have difficulty expressing needs; uses gestures or points
- Inability to understand what others are saying
- Lack of speech or impaired speech patterns
- Impaired pitch, stress, rate, volume or rhythm of speech
- Difficulty with abstract concepts and rational terms
- Indicate needs by gesture
- Generally do not initiate requests
- Pronoun reversals
- Parroting of responses, both literally or as a question
- Poor quality and quantity of receptive/expressive language

Autism and Repetitive Activities

---

overhead - Autism and Repetitive Activities

Persons with autism may have a preoccupation with:

- Matching, pairing and ordering objects
- Blinking compulsively
- Switching lights on and off
- Dropping things repetitively
- Jumping
- Rocking
- Rocking from one foot to another
- Hand-shaking
- Flicking objects
- Chin-tapping
- Head-banging
- Clapping
- Tearing paper
- Breaking glass
- Spinning things, spinning oneself or running in circles
- Fascination for colored and shiny objects

Major Aspects

Autism is the least understood of the major categories of DD. While research on this condition has over a 50 year history, much has yet to be learned. Persons with autism are subject to behavioral changes, and these typically represent the occasions when police are involved due to a non-understanding by others. Persons with autism have experienced countless injustices by the criminal justice system, of which many of these incidences have raised the level of awareness on the part of society for the need for police training on all the categories of DD.

The vast majority of research on persons with this condition has been conducted on/with children. Until recently, children with autism never grew up to be called adults with autism. Instead, they were called schizophrenic or mentally retarded, and were usually institutionalized. Why were adults with autism not called *autistic*? Until recently, there were not residential, training or employment opportunities for adults with autism, so the only way they could receive services was to be labeled something else. Once labeled, the easiest thing to do was to shut them away in institutions.

Now more services are available for adults with autism and as a result more people have finally begun to see adults with autism for who they are. They are people who usually require intensive, continuing training in order to lead fulfilling lives. The more they are capable of satisfying their own needs and wants, the happier they will be. Children with autism usually carry with them into adulthood the same behavior, preferences and demands they have had throughout life. This can be both good and bad as undesirable behavior does not end by entering adulthood. Many adults with autism retain their need for sameness and continue to throw temper tantrums. The good news is that adults with autism do not usually acquire new behavior problems, nor do they lose the progress they have made in controlling their behavior and in meeting their own needs (Holmes, 1989).

Although the diagnostic criteria for autism has become increasingly refined, accurate diagnosis can be complicated by several factors. First, there are no medical tests or biological markers, thus the sole determination is behavioral based. As there are no physiological tests at this time to determine whether a person has autism, the diagnosis of autism is given when an individual displays a number of characteristic behaviors. Because of its low prevalence, few professionals receive little exposure to persons with autism in the course of their training and are unfamiliar with its behavioral expression.

The second problem arises due to the fact that characteristics and behavioral manifestations often vary as a function of age or developmental level. Diagnostic features prominent during the preschool years may not be the same as those seen in middle childhood. A third factor is that of overlapping conditions between autism and other forms of DD. Lastly, the body of knowledge about autism continues to expand and therefore many facts become outdated.

Many autistic infants are different from birth. Two common characteristics they may exhibit include arching their back away from their caregiver to avoid physical contact and failing to anticipate being picked up (i.e., becoming limp). As infants, they are often described as either passive or overly agitated babies. A passive baby refers to one who is quiet most of the time making little, if any, demands on his/her parents. An overly agitated baby refers to an infant who cries a great deal, sometimes non-stop, during his/her waking hours. During infancy, many begin to rock and/or bang their head against the crib; but this is not always the case.

In the first few years of life, some autistic toddlers reach developmental milestones, such as talking, crawling and walking,

much earlier than the average child; whereas others are considerably delayed. Approximately one-third of autistic children develop normally until somewhere between 1 and 1/2 to 3 years of age; then autistic symptoms begin to emerge. These individuals are often referred to as having *regressive* autism. Some people in the field believe that vaccinations and exposure to a virus, or the onset of seizures may be responsible for this regression.

During childhood, autistic children may fall behind their same-aged peers in the areas of communication, social skills, and cognition. In addition, dysfunctional behaviors may start to appear, such as self-stimulatory behaviors (i.e., repetitive, non-goal directed behavior, such as rocking, hand-flapping), self-injury (e.g., hand-biting, head-banging), sleeping and eating problems, poor eye contact, insensitivity to pain, hyper-hypo-activity, and attention deficits.

One characteristic which is quite common in autism is the individual's "insistence on sameness" or "perseveration" behavior (continuation of something to an exceptional degree). Many persons become overly insistent on routines; if one is changed, even slightly, the child may become upset and tantrum. Some common examples are: drinking and/or eating the same food items at every meal, wearing certain clothing or insisting that others wear the same clothes and going to places away from the home using the same route. One possible reason for "insistence on sameness" may be the person's inability to understand and cope with novel situations.

Autistic individuals sometimes have difficulty with the transition to puberty. Approximately 20% have seizures for the first time during puberty which may be due to hormonal changes. In addition, many behavior problems can become more frequent and more severe during this period. However, others experience puberty with relative ease.

There is no adjective which can be used to describe every type of person with autism because there are many forms of this disorder. For example, some individuals are anti-social, some are asocial and others are social. Some are aggressive toward themselves and/or aggressive toward others. Approximately half have little or no language, some repeat (or echo) words and/or phrases and others may have normal language skills.

In contrast to 20 years ago when many autistic individuals were institutionalized, there are now many flexible living arrangements. Usually, only the most severe individuals live in institutions. In adulthood, some people with autism live at home with their parents; some live in residential facilities; some live

semi-independently (such as in a group home); and others live independently. There are autistic adults who graduate from college and receive graduate degrees, and some develop adult relationships and may marry. In the work environment, many autistic adults can be reliable and conscientious workers. Unfortunately, these individuals may have difficulty getting a job. Since many of them are socially awkward and may appear to be *eccentric* or *different*, and they often have difficulty with the job interview.

Prevalence of Autism

Autism is a rare disorder, yet its prevalence rate makes it the third most common developmental disorder. The most cited statistic is that autism occurs in 4.5 out of 10,000 live births (Stone & Ousley, 1996). This is based on large-scale surveys conducted in the United States and England. However, other recent studies have found substantially higher prevalence rates, ranging from 10 to 15 persons with autism per 10,000; this suggests that autism may be more common than previously thought (Gillingham, 1997). In addition, the estimate of children having autistic-like behaviors is 15 to 20 out of 10,000 (Van Bourgondien, 1987). Interestingly, estimates on the prevalence of autism vary considerably depending on the country, ranging from 2 out of 10,000 in Germany to as high as 16 out of 10,000 in Japan. Possible reasons for the discrepancy in prevalence rates may be due to differing diagnostic criteria, genetic factors and/or environmental influences.

Autism is four times more likely to affect males than females (Stone & Ousley, 1996). Gender ratios seem to differ as a function of intellectual ratio, with a higher percentage of females found at lower intellectual levels. This gender difference is not unique to autism since many developmental disabilities have a greater male to female ratio.

Autism appears to be distributed equally among all social classes. Early work with this disorder led researchers to believe that it appeared more often to families of upper social status. That has since been disapproved as investigators began to realize that upper class families were probably more likely to have the resources that enabled them to find programs that involved diagnostics. Recent trends toward increased recognition of autism and wider availability of public funding for services have led to greater access for families at lower levels.

Intelligence and Autism

While the entire range of intelligence is possible for persons with autism, frequently persons with autism may show an

unevenness of development precipitating a display of talent in certain limited areas such as music or mathematics, while being deficient in areas related to living skills, including their ability to communicate and relate to others. Most persons with the condition need structure, supervision and guidance in much of what they do.

Approximately 70 percent of all persons with autism function within the mentally retarded range. Persons of any age with autism do not test up to their abilities because these results are probably affected by the communications difficulties associated with the condition. Many develop seizures during adolescence and this tends to be those of IQ scores less than 70. It is rare to find seizures in persons with autism and a normal IQ. About 10% of autistic individuals have exceptional intellectual skills by most standards. These skills are often spatial in nature, such as special talents in music and art. Another common savant skill is mathematical ability in which some autistic individuals can multiply large numbers in their head within a short period of time; others can determine the day of the week when given a specific date in history or memorize complete airline schedules.

Many autistic individuals do not realize that others may have different thoughts, plans and perspectives than their own. For example, a person with autism may be asked to show a photograph of an object to another person. Rather than turning the picture around to face the other person, the person with autism, may instead, show the back of the photograph. In this example, the persons with autism can view the picture but does not realize that the other person has a different perspective or point of view.

Causes of Autism

Although there is no known unique cause of autism, there is growing evidence that autism can be caused by a variety of problems. There is some indication of a genetic influence in autism. For example, there is a greater likelihood that identical twins will have autism than fraternal twins. This is explained as with identical twins there is a 100 percent overlap in genes; whereas in fraternal twins, there is a 50% overlap in genes, the same overlap as in non-twin siblings. In a survey conducted in Utah, researchers identified 11 families in which the father had autism. Of the 11 families, there was a total of 44 offspring, 25 of whom were diagnosed as having autism. Other research has shown that depression and/or dyslexia are quite common in one or both sides of the family when autism is present.

There is also evidence that a virus can cause autism. There is an increased risk in having an autistic child after exposure to

rubella during the first trimester of the pregnancy. Additionally, there is speculation that viruses associated with vaccinations, such as the rubella vaccine and the pertussis component of the DPT shot, may cause autism.

The cerebellum is a relatively large portion of the brain and is located near the brain stem. It is primarily responsible for motor movements, and damage to this area during the birth process can cause cerebral palsy, a disorder characterized by uncontrollable motor movements. There is also some recent evidence that the cerebellum is partially responsible for speech, learning, emotions and attention. Damage to this portion of the brain is one possible reason that persons with autism may experience differences with speech, learning, emotions and attention.

Although there is no scientific evidence at this time, there is growing concern that toxins and pollution in the environment can also lead to autism. There is a high prevalence of autism in the small town of Leomenster, Massachusetts, where a factory manufacturing sunglasses was once located. Interestingly, the highest proportion of autism cases were found in the homes down-wind from the factory smokestacks.

Physical Differences

Researchers have located several brain abnormalities in individuals with autism; however, the reasons for these abnormalities is not known nor is the influence they have on behavior. These abnormalities are detected through postmortem studies. Many of the reported abnormalities are not consistent from one study to another. The most consistent finding in autistic populations has been increased or in some cases decreased levels of serotonin in their blood and cerebral spinal fluid (Stone & Ousley, 1996). Serotonin is thought to regulate a number of behavioral processes, including pain and sensory perception, motor function and learning and memory. It should be mentioned that other disorders, such as Down Syndrome, attention deficit/hyperactivity disorder and unipolar depression are also associated with abnormal levels of serotonin.

The scientific community tells us that the senses of the individual with autism are very acute. The human body has a biochemical means to deal with pain and these are called *endorphins*. The brain, in an attempt to block out over-stimulation produces added endorphins, which results in the blockage of not only the pain, but also the senses. Endorphins are created as the natural response of the body to counteract pain and anxiety. When in pain or under stress, individuals with autism use repetitive behaviors to produce endorphins. A lack of response to stimulation, demonstrated by those who have autism, can be tied

directly to the amount of endorphins that they have produced through the use of repetitive behaviors (Gillingham, 1997). For the policeman, repetitive behavior should signal that the person is experiencing a sensory overload and has learned how to produce the endorphins as a defense measure to literally shut out the offensive stimuli from the stressful environment of the person with autism.

Some people with autism have excessive amounts of a type of yeast called *candida albicans* in their intestinal tract. This is a type of parasitic fungi that resembles a yeast. It is thought that high levels of candida albicans may be a contributing factor to many of their behavioral problems. One scenario is that when a person with autism develops a middle ear infection, the antibiotics that help fight the infection may destroy microbes that regulate the amount of yeast in the intestinal tract. As a result, the yeast grows rapidly and releases toxins in the blood; and these toxins may influence the functioning of the brain.

Sensory Impairments

---

overhead - Persons with Autism and Sensory Modes

Persons with autism:

- May act as deaf
- May have fear of sound
- May stare at lights
- May be insensitive to pain
- May dislike contact with textures and people
- May lick and/or smell things

Many autistic individuals seem to have an impairment in one or more of their senses. This impairment can involve the auditory, visual, tactile, taste, vestibular, olfactory (smell) and proprioceptive senses. These senses may be hypersensitive, hyposensitive or may result in the person experiencing interference such as in the case of tinnitus (a persistent ringing or buzzing in the ears). As a result, it may be difficult for individuals with autism to process incoming sensory information properly.

Sensory impairments may also make it difficult for the individual to withstand normal stimulation. For example, some autistic individuals are tactilely defensive and avoid all forms of body contact. Others, in contrast, have little or no tactile or pain sensitivity. Furthermore, some people with autism seem to crave deep pressure. Another example of sensory abnormalities is hypersensitive hearing. About 40% of individuals with autism

experience discomfort when exposed to certain sounds or frequencies. These individuals often cover their ears and/or tantrum after hearing sounds such as a baby's cry or the sound of a motor. In contrast, some parents have suspected their child with autism of being deaf because they appeared unresponsive to sounds.

Gillingham (1997) believes that a broader understanding of the sensory processing of persons with autism lies at the root of a better knowledge base about the condition. The scientific community had long thought that nature limits the amount of stimuli coming in and prevents the brain from becoming overloaded with information. Thinking on this matter has recently changed as we now recognize that some persons are supersensitive. According to persons with autism, their disability is linked directly to the senses. While their eyes, ears, nose and skin can seem normal, it is now believed that when sensory messages reach the brain, they are not linked into an understandable picture of the outside world. They describe how the touch of another human being can be excruciating, smells can be overpowering, hearing can hurt, sight can be distorted and tastes may be too strong. In other words, their world can be a world of pain. The development of the autistic personality is, according to Gillingham, their method of coping with pain.

The receiving of faulty messages about the world around them leads to a lack of understanding of speech and gesture and hence a lack of ability to communicate. Because of the missing link in understanding, autistic persons appear to be withdrawn and seem to live in an isolated world of their own. Moveover, the frustration caused by the inability to communicate often leads to disturbed behavior.

Many autistic individuals also have a narrow or focused attention span; this has been termed stimulus over-selectivity. Basically, their attention is focused on only one, often irrelevant, aspect of an object. For example, they may focus on the color of a utensil, and ignore other aspects such as the shape. In this case, it may be difficult for a person with autism to discriminate between a fork and a spoon if he/she attends only to the color. Since attention is the first stage in processing information, failure to attend to the relevant aspects of an object or person may limit one's ability to learn about objects and people in one's environment.

The above principle is important to police officers and others who are trying to initiate a conversation with someone with autism. For most people, it takes a short period of time, less than a second or two, to redirect attention from one stimulus to another

in the environment. In contrast, autistic individuals continue to attend to a stimulus even when prompted for redirection, and they may take three to five seconds or longer to shift their attention. It is thought that many persons with autism have difficulty directing their attention to changes in their surroundings, and by the time they do shift their attention, they lose information regarding context and content. An inability to shift attention in a timely manner may result in their not hearing the first sentence or two that someone else might say. For example, if a person with autism is focusing on an object of any kind and a police officer asks him/her a question, it may take a few seconds before he/she can redirect their attention and listen to the officer. As a result, the person has difficulty understanding the officer because he/she did not attend to the first few sentences. Therefore, it is considered a good practice to repeat the first two sentences of a conversation.

Communicating with Persons with Autism

---

overhead - communicating with persons with autism

As mentioned earlier, persons with autism tend to have extreme limitations with both expressive and receptive language. The police officer might consider the following tips when attempting to communicate with a person with autism.

- Do not use physical contact.
- Be patient.
- The person with autism may lack awareness of or attention to others. The person may have a stand-offish manner.
- A person with autism may be unable to make eye contact.
- Persons with autism may parrot responses of others.
- Use simple language, speak slowly and clearly.
- Use concrete terms and ideas.
- Repeat simple questions, allowing time (10-15 seconds) for a response.
- Proceed slowly and give praise and encouragement.
- Do not attempt to physically stop self-stimulating behavior.
- Talk indirectly, look away and act indifferent.
- Use symbols or objects when talking.

When the person with autism is speaking, the autistic individual needs to know that he/she is being heard. How do you listen without antagonizing him/her? Standing calmly by, without looking intently at the person with autism. The officer should keep in mind that each individual with autism is unique and may

act or react differently. Please contact a responsible person who is familiar with the individual, particularly when attempting to solicit important information.

Conclusion

Autism is a very complex disorder, and the needs of these individuals vary greatly. After 50 years of research, traditional and contemporary approaches are enabling us to understand and treat these individuals. It is also important to mention that professionals are beginning to realize that the symptoms of autism are treatable–there are many interventions that can make a significant difference.

The two treatments which have received the most empirical support are behavior modification and the use of vitamin B6 with magnesium supplements. Vitamin B6 taken with magnesium has been shown to increase general well-being, awareness and attention in approximately 45% of autistic children. There are also a number of recent reports about the benefits of another nutritional supplement, Dimethylglycine (DMG) also seems to help the person's general well-being, and there are many anecdotal reports of it enhancing communication skills.

Allergies and food sensitivities are beginning to receive much attention as possible contributors to autistic behaviors. Many families have observed rather dramatic changes after removing certain food items from their family member's diet. Researchers have recently detected the presence of abnormal peptides in the urine of autistic individuals. It is thought that these peptides may be due to the body's inability to breakdown certain proteins into amino acids; these proteins are gluten (e.g., wheat, barley, oats) and casein (found in human and cow's milk). Many parents have removed these substances from their family member's diet and have, in many cases, observed dramatic, positive changes in health and behavior.

The logo for the national parent support group, the Autism Society of America, is a picture of a child embedded in a puzzle. Most of the pieces of the puzzle are on the table, but we are still trying to figure out how they fit together. We must also keep in mind that these pieces may fit several different puzzles.

Community Resources for Persons with Autism

Texas has 31 community-based MHMR centers with components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource

when needed. In addition many communities will have a local chapter of the Autism Society of America (ASA). The address of the national office as well as other organizations are as follows:

Autism Society of America
7910 Woodmont Avenue, Suite 650
Bethesda, MD 20814
800-328-8576
301-675-0881
fax: 509-534-5245

The Arc
500 E. Border St. #300
Arlington, TX 79010
800-433-5255
817-261-6003
817-277-3491

Suggested Activity using the Trainee's Guide:

1. Check your own general knowledge about autism on page 14 in the Trainee's Guide and answer the questions on page 15. Compare your answers with the answers at the bottom of page 17.
2. Role-Playing Activity: Working as a pair, with one partner role playing the part of the officer and the other team member acting the role of the suspect.

Cerebral Palsy

Objectives

Performance Objective:

Given a subject with Cerebral Palsy involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 24 in the Trainee's Guide. Include such factors as general information, identification, communication and community resources.

Enabling Objectives:

1. **Demonstrate general knowledge of the unique factors of persons with cerebral palsy.**
2. **Role play with another participant with cerebral palsy in a simulated situation.**

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with cerebral palsy. If someone has, ask them to tell of situation and how they

knew the person had cerebral palsy? What were the distinguishing characteristics? Then, present the following incident which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

As an on-duty officer, you are responding to a call from a convenience store that has reported making a sale to a man who was staggering and had slurred speech. The store attendant informs you that he suspected that the person was intoxicated and should not be out in public. The attendant has observed the direction in which the man left the premises and you pursue.

A couple of blocks away you observe the individual and the store attendant's description of the man's walk appears very accurate. You approach, identify yourself and notice the slurred speech as well. What disabling condition might be present and how do you gather additional information regarding his physical and/or mental state?

Identifying Persons with Cerebral Palsy

It is usually easy to identify persons with CP through observable physical manifestations, chief of which is gait disturbance. These persons can have normal intelligence. Physical manifestations can be limited to certain areas of the body; i.e., upper body, lower body, right side, left side, one arm or all. CP can be present in varying degrees. Persons with CP have problems in processing information in terms of where they (and their limbs) are physically and where they perceive themselves to be; therefore, there may be some unusual posturing. Some persons with CP have genius intelligence, yet only with recent innovations is this factor detected.

---

overhead - Identification of Persons with Cerebral Palsy

A person with CP may have the following characteristics:

- Stiff and jerky movements
- Unsteady and shaky
- Poor balance
- Trouble holding themselves in an upright, steady position
- Random, involuntary movements
- Experience seizures
- Muscle imbalance in one of their eyes (lazy eye)

Suggested that participants try this:

Bend your arm to move your hand up to touch your nose. To do that you must shorten, or increase the tone in the muscle in the front of the upper part of your arm (biceps muscle) while you lengthen, or decrease the tone in the back of the upper part of your arm (triceps muscle). To move your arm smoothly without jerks and without hitting yourself in the nose, the tone in muscles used to make that movement must change in a way that is just right – an even change to tighten one while loosening the other. Persons with CP are not able to change their muscle tone in a smooth and even way, so their movements may be jerky or wobbly.

What is Cerebral Palsy?

Cerebral Palsy (CP) is a functional disorder caused by damage to the brain during pregnancy, delivery or shortly after birth. Sometimes injuries to a baby's brain happens while the baby is still in the mother's womb (before birth). The injury might be caused by an injection or by an accident in which the mother is hurt. If a mother has a medical problem such as high blood pressure or diabetes, this can also cause problems with the baby. There may be problems during birth, such as the baby not getting enough oxygen, or a difficult delivery in which the baby's brain is injured. Problems after birth may happen when a baby is born too soon (premature delivery) and his/her body is not ready to live outside the mother's womb. Even babies born at the right time can have infections, or bleeding in their brain which causes a brain injury because the brain is still developing even after birth.

The words ***cerebral palsy*** are used to describe a medical condition that affects control of the muscles. ***Cerebral*** means brain or anything in the head, and ***palsy*** means a disorder of movement or posture. Palsy also refers to anything wrong with control of the muscles or joints in the body. If someone has cerebral palsy it means that because of an injury to their brain (that is the cerebral part) that they are not able to use some of the muscles in their body in the normal way (that's the palsy part). Persons with CP may not be able to walk, talk, eat, or participate in other activities in the same ways that non-disabled persons do.

Cerebral Palsy is the term used to describe the motor impairment resulting from brain damage. Cerebral Palsy is caused by damage to the brain with the damage varying in location and extent. CP is a non-progressive disorder of motion and posture due to a brain insult or injury during the period of early brain growth (prenatal up to 5 years).

No event is an absolute predictor of CP. Most sources report that a minimum of 50% of the cases result from trauma during birth. In addition, the major source of trauma appears to be severe asphyxia (a lack of sufficient oxygen to the brain). What is not clear is whether asphyxia causes cerebral palsy or that asphyxia is a symptom of an otherwise sick baby with other neurological problems.

The risk of CP is drastically increased for babies born with very low birth weights. Premature babies are at a much higher risk for developing cerebral palsy than full-term babies, and the risk increases as the birth-weight decreases. Babies weighing less than three pounds are 25 times more likely to develop cerebral palsy than infants who are born at full term weighing more than five pounds.

Progress in medical science regarding the care of babies with low birth weight is contributing to more babies surviving with CP. One proven test for determining CP is when a premature baby does not cry within five minutes following birth. Babies who have congenital malformations in systems such as the heart, kidneys, or bones are also more likely to develop CP, because they also have malformations in the brain. A new born that has seizures also has an increased risk of developing CP.

CP is a static, non-progressive disorder of movement and posture due to injuries of the brain sustained during the early developmental period. The term *stable non-progressive neurologic disorder* is sometimes used for this for this disorder (Blackman, 1987). CP is not temporary and it does not get worse. CP is not a single disorder but a group of non-progressive disorders, with multiple causes and manifestations, that usually result in some degree of permanent impairment of motor function.

Cerebral Palsy can affect different parts of the body, and can be manifested by a wide variety of movement problems. It can result in restricted movement or extraneous, uncontrolled movements. Spasticity, which refers to the inability of a muscle to relax occurs in about 60% of all cases of CP. Spasticity results in reduced movement due to an increased resistance of fast stretching muscles that give way. The distribution of affected body regions can vary with the most common including the trunk and all four extremities with the legs more affected than the arms. Most estimates of all persons with CP indicate that 35% to 45% experience seizures (Miller & Bachrach, 1995). The involuntary movements of dyskinesia are made worse as a result of heightened emotional states.

Individuals with CP frequently manifest nutritional deficiencies because of difficulties in swallowing. In addition,

many of those affected have extra caloric needs. Approximately 1 in 8 have hearing defects. Many persons with CP have normal intelligence, yet appear to be retarded. It is common for persons to have better receptive (understanding) than expressive (speech) language skills.

Because CP is a condition caused by damage to the central nervous system, many of the complications of CP are neurological. Persons of all ages with CP may also have orthopedic problems, that is problems with the spine, bones, joints, muscles or other parts of the skeletal system. CP may manifest as a combination of impairments involving multiple body systems. Persons with CP may also have problems that are *secondary* to neurological and orthopedic conditions. An example of a secondary effect of CP is poor nutrition caused by difficulty in swallowing. For some persons with CP, one of these kinds of problems may dominate and the CP will be a relatively minor issue. For example, some persons with CP may be able to walk and have few physical limitations, yet manifest some degree of mental retardation.

Prevalence Rate of CP

The generally accepted incidence of CP is 5 per 2000 persons and this seems to remain constant in the United States (Miller & Bachrach, 1995). Life expectancy is normal and the estimated living American population, using the above formula, with CP is about 650,000.

---

overhead - Facts About CP

- CP is not a disease, it is not inherited, it is not contagious, it does not get worse, neither is there a cure.
- About 25% of cases result from prenatal causes such as from a virus, unnecessary x-rays, drugs, anemia, lack of proper nutrition and premature delivery.
- About 40% of cases are caused by lack of oxygen or in injury during birth or shortly after.
- About 30% of the causes are unknown.
- Occurs to some degree in about 2.5 out of 1,000 live births.

The most important thing to remember is that cerebral palsy is not contagious and you do not develop CP later in life. It is caused by an injury to the brain near the time of birth. Cerebral palsy is generally classified according to the type of movement problem. Motor ability and coordination vary greatly from one person affected to another, and there are very few statements that

hold true for all persons with CP. The word for the dominant type of movement or muscle coordination problem is often combined with the word for the component that seems to be most problematic for the person with CP. Thus generalizations about CP can only have meaning within the context of the following subgroups.

Types of Cerebral Palsy

---

overhead - Classifications by Type of Movement

- Spasticity - tight limb muscles
- Athetosis - involves purposeless movement
- Rigidity - severe form of spasticity, usually quadriplegic (involving arms and legs).
- Cerebral Ataxia - lack of balance
- Mixed - muscle tone differences

Persons with CP have damage to the area of their brain that controls muscle tone. Depending on where their brain injury is and how big it is, their muscle tone may be too tight, too loose or a combination of the two. Muscle tone is what lets us keep our bodies in a certain position like sitting with our heads up to look at your instructor in this class. Changes in muscle tone let us move.

Spastic Cerebral Palsy

Spasticity refers to the inability of a muscle to relax. If muscle tone is too high or too tight, the term spastic is used to describe the type of cerebral palsy. Persons with spastic CP have stiff and jerky movements because their muscles are too tight. They often have a hard time moving from one position to another or letting go of something in their hand. This is the most common type of CP as most sources believe that a minimum of 60% of all people with CP have spastic CP (Miller & Bachrach, 1995).

Ataxic Cerebral Palsy

Low muscle tone and poor coordination of movements is described as *ataxic* (a-tax-ick) CP. Persons with CP look very unsteady and shaky. They have a lot of shakiness, similar to a tremor you might have seen in very old persons, especially when they are trying to do something like write or turn a page or cut with scissors. They also often have very poor balance and may be very unsteady when they walk. Because of the shaky movements and problems coordinating their muscles, persons affected may take longer to finish a task that involves skills such as writing.

Athetoid Cerebral Palsy

The term *athetoid* is used to describe the type of CP when muscle tone is mixed - sometimes to high and sometimes too low. Therefore these individuals lack the ability to control the movement of a muscle. Persons affected have trouble holding themselves in an upright, steady position for sitting or walking, and often show lots of movement of their face, arms and upper body that they do not mean to make (random, involuntary movements). These movements are usually **big**. It takes an extra amount of work and concentration for many persons with this type of CP to get their hand to a certain spot like to scratch their nose or reach for a cup. Because of their mixed tone and trouble keeping a position, they may not be able to hold onto things such as a toothbrush, fork or pencil. Athetoid CP occurs in about 10 percent of all cases of CP, thus is the least common type (Miller & Bachrach, 1995).

Rigidity

Persons with this level of CP are generally quadriplegic which implies that all four extremities as well as trunk and neck muscles are impaired. These individuals have a heightened level of spasticity. The term *rigidity* is generally synonymous with stiffness. Some persons with CP become very stiff, especially in the joints. Spasticity is generally due to the muscles being very tight and then suddenly relaxing. When the stiffness does not suddenly relax but slowly stretches out, with the feeling of bending a lead pipe, then the term used is rigidity.

Mixed CP

When muscle tone is too low in some muscles and too high in other muscles, the type of CP is called *mixed.*

Conditions that Frequently Accompany Cerebral Palsy

Because CP is a condition caused by damage to the central nervous system, many of the complications of CP are neurological. Persons with CP may also have orthopedic problems that affect the spine, bones, joints, muscles or other parts of the skeletal system. In addition, they may also have problems that are considered "secondary" to the neurological and orthopedic problems. One example of a secondary effect of CP is poor nutrition caused by the person's difficulty in swallowing. Other neurological problems associated with CP include:

---

overhead - Neurological Problems Associated with CP

- seizures and epilepsy
- mental retardation
- learning disabilities
- attention deficit-hyperactivity disorder

- hydrocephalus (enlargement of fluid-filled spaces surrounding the brain)
- behavior problems
- visual impairments
- hearing loss
- speech impairment
- swallowing difficulties

All of the above conditions have implications for the law enforcement official assisting/investigating a scene involving a person with CP. As mentioned earlier, slightly less than one-half may experience seizures. A seizure (also called a convulsion) occurs when bursts of disorganized electrical energy interfere with normal brain functioning. Electrical bursts of this sort can occur in different parts of the brain and can result in different kinds of seizures. The most common kind of seizure for the person with CP is the *grand mal seizure*. This is a generalized type of seizure involving the entire body. The officer needs to remember that this may involve a loss of consciousness, alternating rigidity and relaxation of muscles and a period of drowsiness or disorientation. Regardless of the disposal of the situation, the person must continue to receive the medication that assists with the control of the seizures.

Persons with CP may have intelligence within the entire range of possibilities. They do tend to experience difficulty with speech, partly because of the possibility of impaired hearing, and have difficulty in writing and problem solving that involves a concentrated focus. Much of what non-disabled persons perceive is the result of being able to freely move around objects and see all dimensions. Persons with CP generally are lacking in mobility skills and thus their perceptual skills may be not as well developed as their non-disabled counterparts (Alexander & Bauer, 1988).

In the discussion of spastic CP we talked about the inability of muscles to relax. Nearly one-half of the persons with spastic CP have a muscle imbalance in one of their eyes resulting in what is commonly called *cross-eye*. In addition, the absence of adequate oxygen during birth tends to impair vision. As many as 80 percent of the persons with CP suffer from a *lazy eye*.

Community Resources for Persons with Cerebral Palsy

Texas has 31 community-based MHMR centers with M-R components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource when needed. In addition many communities will have a local

chapter of the United Cerebral Palsy Association. The address of the national office as well as other organizations are as follows:

United Cerebral Palsy
1522 K Street NW, Suite 1112
Washington, DC 20005
1-800-872-5827

The Arc
500 East Border St., Suite 300
Arlington, TX 79010
1-817-261-6003 1-800-433-5255

National Association of Developmental Disabilities Councils
1234 Massachusetts Ave. NW, Suite 103
Washington, DC 20005
1-202-346-1234

Epilepsy Foundation
4351 Garden City Drive
Landover, MD 20785
1-800-332-1000

National Easter Seal Society
70 East Lake Street
Chicago, IL 60601
(312) 726 - 6200 (voice)
(312) 726 - 1494 (FAX)
(312) 726 - 4258 (TDD)
or the Easter Seal Society in your community.

American Academy for Cerebral Palsy and Developmental Medicine
P.O. Box 11086
Richmond, VA 23230-1086
(804) 282 - 0036

Children with Special Health Care Needs Program
Division of Maternal and Child Health
Health Resources and Services Administration
U. S. Department of Health and Human Services
Parklawn Building, Room 6-05
5600 Fishers Lane
Rockville, MD 20857
(301) 443 - 2350

UCPA National office:
United Cerebral Palsy Associations, Inc.
710 Plaza, Suite 804
New York, NY 10001
(212) 268 - 6655
or the United Cerebral Palsy affiliate in your community.

United Cerebral Palsy's mission is (1) to promote and provide the mechanisms for independent growth, self determination and community inclusion for persons with cerebral palsy and other persons with disabilities and their families, and (2) to promote community awareness of cerebral palsy and other disabilities.

There are 155 United Cerebral Palsy affiliates located throughout the country sharing the common goal of providing direct services and advocacy for individuals with cerebral palsy and other disabilities.

Program services for children often include infant and early childhood development programs for children ranging in age from 0-3 years. These programs include center-based, home-based and, as needed, hospital-based services. Some chapters assist families in securing day care in their communities. Also, many chapters maintain a registry of qualified respite providers to assist families in choosing short term in-home respite care.

Program services for adults generally include adult personal development and training sessions. A new emphasis is to create more opportunities for community inclusion of the participants through small group activities. Some local chapters feature community integrated employment programs, designed to assist individuals with CP and related conditions to obtain employment in the mainstream workforce.

Case management services are available at many locations to all program participants and individuals from the community. Individuals not attending agency programs are offered case management assistance in locating generic services and specific agency assistance. Speakers are available to present a number of topics related to cerebral palsy and other disabilities.

Suggested Activity using the Learner's Guide:

1. Check your own general knowledge about **cerebral palsy** on page 20, and answer the self-check questions on page 21. Compare your answers with the answers on page 23.
2. Role-Playing Activity: Working as a pair, with one partner role playing the part of the officer and the other team member acting the role of the suspect.

Epilepsy

Objectives

Performance Objective:

Given a subject with Epilepsy involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 30 in the Trainee's Guide. Include such factors as general information, identification, communication, and community resources.

Enabling Objectives:

1. **Demonstrate your general knowledge of the unique factors of persons with epilepsy.**
2. **Role play with another participant with epilepsy in a simulated situation.**

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with epilepsy. If someone has, ask them to tell of situation and how they knew the person had autism. What were the distinguishing characteristics? Then, present the following incident which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

As an officer, you have arrested a man on suspicion of burglary and he is riding in the back of your police cruiser on the way to the police station. Suddenly, he lets out a hoarse cry, stiffens and begins to jerk his body rhythmically. You tell him to stop but he does not respond. You arrive at the station and he is slumped over and uncooperative. What do you suspect his disabling condition is and how should you respond?

Identifying Persons wtih Epilepsy

---

overhead -- Identifying Persons with Epilepsy

In general, people with epilepsy:

- are indistinguishable from people who do not have epilepsy unless a seizure is taking place or has just taken place.
- are generally as intelligent, perceptive and articulate as any other member of the public, although occurrence of a

seizure will mask these attributes until the person is fully recovered.

- are employed and maintain the same kind of social and familial relationships as other people.
- are unable to interact with other people or to respond appropriately to the environment during a seizure. They often cannot follow directions, converse with others and are generally out of touch with reality until the episode ends and normal brain activity returns.

However, some people with epilepsy may have other physical disabilities including mental retardation, cerebral palsy, autism or mental illness. Additionally, persons may experience social problems such as poverty, homelessness, drug addiction or alcoholism. Because these problems may interfere with consistent access to seizure-preventing medicines, this population may be more likely to have seizures than other people with epilepsy and to have them in settings or circumstances that will lead to police attention.

Show video: ***Take Another Look - Police Response to Seizures and Epilepsy.***

What is Epilepsy

Epilepsy is a word derived from the Greek term *epilepsia* which means to seize (Hermann, Desai, & Green, 1988). Epilepsy is one of the oldest known disorders and was studied and discussed in some detail by Hippocrates (the Father of Medicine) over 2,000 years ago. Physicians of that era were fascinated by the mysteries of epilepsy, its many causes and manifestations. Although the condition is studied today using very scientific procedures, much of the mystery remains.

In addition to these medical mysteries, epilepsy has long been surrounded by social confusion and stigmatization. The term seizure dates back in history as during the middle ages when epileptics were believed to be seized by the devil and were despised and abused. On the other hand, the Romans displayed care for persons with epilepsy as they believed that epileptics were possessed by Gods. The condition is a disorder of the brain with the major characteristic being seizures. Epilepsy is not a disease, nor is it contagious. It is the symptom of a brain dysfunction with the malfunctioning due to an electrical outburst within the cells. These recurrent discharges affect the normal operation of the

nervous system. The result of this electrical *storm* within the brain is a seizure.

The American Heritage Dictionary defines epilepsy as any of various neurological disorders characterized by sudden, recurring attacks of motor, sensory or psychic malfunction with or without loss of consciousness or convulsive seizures. Epilepsy is marked by disturbed electrical rhythms of the central nervous system. These attacks are typically manifested with a clouding of consciousness.

Epilepsy is a neurological condition that from time to time produces brief disturbances in the normal electrical functions of the brain. Normal brain function is made possible by millions of tiny electrical charges passing between nerve cells in the brain and to all parts of the body. When someone has epilepsy, this normal pattern may be interrupted by intermittent bursts of electrical energy that are much more intense than usual. They may affect a person's consciousness, bodily movements or sensations for a short time.

These physical changes are called epileptic seizures. That is why epilepsy is sometimes called a seizure disorder. The unusual bursts of energy may occur in just one area of the brain (partial seizures), or may affect nerve cells throughout the brain (generalized seizures). Normal brain function cannot return until the electrical bursts subside. Conditions in the brain that produce these episodes may have been present since birth, or they may develop later in life due to injury, infections, structural abnormalities in the brain, exposure to toxic agents or for reasons that are still not well understood. Many illnesses or severe injuries can affect the brain enough to produce a single seizure. When seizures continue to occur for unknown reasons or because of an underlying problem that cannot be corrected, the condition is known as epilepsy. Epilepsy affects people of all ages, all nations and all races. Epilepsy can also occur in animals, including dogs, cats, rabbits and mice.

What is the Difference Between Seizures and Epilepsy?

Seizures are a symptom of epilepsy. Epilepsy is the underlying tendency of the brain to produce sudden bursts of electrical energy that disrupt other brain functions. Epileptic seizures are the result of electrical discharges in one or more areas of the brain. These discharges can be monitored and recorded using an E.E.G. machine, allowing doctors to locate the area of the brain causing the seizures. Having a single seizure does not necessarily mean a person has epilepsy. High fever, severe head injury, lack of oxygen–a number of factors can affect the brain enough to cause a single seizure. Epilepsy, on the other hand, is an underlying

condition (or permanent brain injury) that affects the delicate systems which govern how electrical energy behaves in the brain, making it susceptible to recurring seizures.

The seizure is a reaction of the body to the abnormal electrical outbursts within the brain. Not all seizures are the result of epilepsy. Seizures can result from low blood sugar, infection, and fever, without a person having the condition. When seizures recur, when they are unpredictable and without apparent medical cause, it may be epilepsy. Seizures that result in motor disturbances are labeled *convulsions.* Seizures may involve disturbances in mental or physical areas of the body or both.

What Causes Epilepsy?

In about seven out of ten people with epilepsy, no cause can be found. Among the rest, the cause may be any one of a number of things that can make a difference in the way the brain works. For example, head injuries or lack of oxygen during birth may damage the delicate electrical system in the brain. Other causes include brain tumors, genetic conditions (such as tuberous sclerosis), lead poisoning, problems in development of the brain before birth and infections like meningitis or encephalitis. Epilepsy is often thought of as a condition of childhood, but it can develop at any time of life. About 30 percent of the 125,000 new cases every year begin in childhood, particularly in early childhood and around the time of adolescence. Another period of relatively high incidence is in people over the age of 65.

Most occurrences of epilepsy are without a known cause. A more limited number can be traced to a direct cause such as a lack of oxygen at birth, infectious diseases, poisons, strokes, head injuries, genetic factors, drug use, chromosomal abnormalities and health problems during pregnancy. In the majority of cases there is no direct reason why a person may have epilepsy.

How is Epilepsy Diagnosed?

The doctor's main tool in diagnosing epilepsy is a careful medical history with as much information as possible about what the seizures looked like and what happened just before they began. A second major tool is an electroencephalograph (EEG) . This is a machine that records brain waves picked up by tiny wires taped to the head. Electrical signals from brain cells are recorded as wavy lines by the machine. Brain waves during or between seizures may show special patterns which help the doctor decide whether or not someone has epilepsy. Imaging methods such as CT (computerized tomography) or MRI (magnetic resonance imaging) scans may be used to search for any growths, scars or other physical conditions in the brain that may be causing the seizures. In a few research centers, positron emission tomography

(PET) imaging is used to identify areas of the brain which are producing seizures.

How is Epilepsy Treated?

Epilepsy may be treated with drugs, surgery or a special diet. Of these treatments, drug therapy is by far the most common, and is usually the first to be tried. A number of medications are currently used in the treatment of epilepsy. These medications control different types of seizures. People who have more than one type of seizure may have to take more than one kind of drug, although doctors try to control seizures with one drug if possible. A seizure preventing drug (also known as an anti-epileptic or anti-convulsant drug) won't work properly until it reaches a certain level in the body, and that level has to be maintained. It is important to follow the doctor's instructions very carefully as to when and how much medication should be taken. The goal is to keep the blood level high enough to prevent seizures, but not so high that it causes excessive sleepiness or other unpleasant side effects.

While medical treatment through medication is the mainstay, side effects are common. An ideal drug would be one that prevents or stops all seizures, does not sedate the person, is free of side effects and has no cumulative side effects. As such a drug does not exist, physicians balance gains obtained by using a particular drug against its side effects. The entire spectrum of side effects is possible including trouble with balance and walking when blood levels of some common drugs are excessively high. Other side effects include making the skin itch, noticeable smell in perspiration and breath and involuntary eye movements.

How can People Guard Against Seizures?

A person with epilepsy can help control his or her seizures by taking the prescribed medication regularly, maintaining regular sleep cycles, avoiding unusual stress and working closely with his or her physician. Regular medical evaluation and follow-up visits are also important. However, seizures may occur even when someone is doing everything he or she is supposed to.

Additional Facts

---

overhead - Facts on Epilepsy

- There are over 2.6 million Americans with epilepsy.
- There are about 125,000 new cases of epilepsy that occur each year.
- Most individuals with epilepsy can be helped with medications.

- There are over twenty kinds of seizures associated with epilepsy.
- One of the most significant problems associated with epilepsy is people's attitudes.
- Everyone maintains a certain degree of susceptibility to seizures
- There are over 300,000 students with epilepsy in schools in the U.S.

Prevalence Rate of Epilepsy

The prevalence of epilepsy varies by source with some figures ranging as high as three percent. At a minimum it is found in approximately 1 out of every 100 persons (Michael, 1995). One reason that this figure varies is because of the stigma and prejudice associated with this disorder. The same source cites the fact that one out of every 10 persons will have at least a single seizure at some point in their life and for 80 percent of those it will be their only seizure. Persons with isolated seizures are not classified has having epilepsy. The rates of epilepsy are higher in males than in females. The frequency among individuals of Afro-American heritage is higher than for traditional American whites. Males have a higher tendency to receive genetic traits, yet the reasons for persons of color to have elevated rates are thought to be many, including poorer perinatal care.

Seizure threshold refers to the susceptibility of a person to have seizures. A low threshold indicates that a person would be more apt to experience a seizure. There are a number of factors which could affect a person's threshold such as heredity, photosensitivity (flashing lights), extreme fatigue, stress, hormonal changes and growth periods and missed medications.

The intelligence range for persons with epilepsy, as measured by IQ tests is the same as the general population (Michael, 1995). Some sources report a slight reduction in intelligence scores, but this is generally attributed to medication. Seizures generally do not affect one's intelligence, unless the seizures occur often and are quite severe. One of the most commonly reported cognitive deficits in individuals with epilepsy has been memory. Memory, however, can be influenced by a number of factors, such as the type of seizure, duration, origin, frequency and medications.

Epilepsy, as a disabling condition is considered to be a major developmental disability. By occurring at higher rates, epilepsy is related to other specific disabilities. Although there are numbers of other conditions related to epilepsy, primary concern here is given to mental retardation, autism, cerebral palsy, multiple disabilities, multiple sclerosis and traumatic brain injury.

Types of Seizures

Many types of seizures exist with most sources generally using two major categories that are further subdivided into nine seizure classifications. The categories and classifications are used as guidelines to determine the severity of a person's epilepsy (Hermann, Desai, & Whitman, 1988). Knowledge of the common characteristics of a seizure classification helps to anticipate the victim's actions during the seizure. The nine seizure classifications are:

---

overhead - Classifications of Seizures

Generalized Seizures

- Tonic-Clonic (grand mal)
- Absence (petit mal)
- Myoclonic
- Tonic
- Clonic
- Atonic

Partial Seizures

- Simple-Partial Seizures (consciousness not impaired)
  With motor signs (Jacksonian)
  With somatosensory and special sensory signs
  With automatic signs
  With psychic symptoms
- Complex-Partial Seizures (consciousness impaired)
  Simple-Partial–Impaired consciousness
- Secondarily Generalized (partial onset evolving to generalized tonic-clonic seizures)

There are two main categories of seizures: *generalized* and *partial*. It is important for the police officer to remember that behavior is out of control for persons experiencing seizures of either category. **Generalized Seizures** are those that affect the whole brain at once. The following are types of generalized seizures.

- **Tonic-Clonic Seizures** - also known as *grand mal* Seizures are the most common type experienced by persons of all ages (when including children) and characterized by stiffening of the entire body, followed by jerking muscle contractions. These seizures are associated in most people's minds with the words *convulsion* or *fits*. The individual may lose consciousness and bladder control during this seizure. There are 4 stages of Tonic-Clonic seizures:
  Aura: Signs warning the individual or others that a seizure is about to occur. Some persons may notice their aura in time enough to get to a safe area for their seizure. For

others, the aura would occur immediately before the seizure starts. Some persons affected are overcome by fear when the aura occurs and scream for help. The aura is the panic felt before the seizure. Other signs may include a bad taste in the mouth, ringing in the ears, strange smell, flashing of lights or tingling sensation to parts of their body. Within seconds, the individual loses consciousness, falls, and becomes very stiff (*tonic* phase). A few seconds later there is jerking of the limbs (*clonic* phase), the eyeballs roll up, the individual has frothing at the mouth and may bite his or her tongue. In about a minute the jerking stops and the person falls asleep for 1 to 3 hours. This is the *post-ictal* phase in which the person gradually returns to consciousness in which mental confusion, stupor, slurred speech and weakness may occur. This phase potentially can be dangerous as the person may engage in limited actions without being aware of what they are doing. The tonic-clonic seizure may leave the subject exhausted, with a headache, and with whatever wounds they would receive during the seizure such as bites in the cheek and tongue, body bruises, etc.

Suggested first aid for such a seizure includes laying the individual flat on the ground, turning the head to one side and waiting for a minute or two. The seizure will generally stop in this time. During the seizure, the person is unaware of what is going on. After the seizure is over, the individual will generally be confused, will not recall what was said during the seizure, nor will he or she remember what happened during the seizure. Most persons who have these seizures tend to have only one at a time.

It is an extreme medical emergency when there are a flurry of seizures (Hermann, et al., 1988, p.248). Prolonged general seizures known as *status epilepticus*, also known as seizure status, is characterized by multiple seizures occurring simultaneously without a break in between the seizures or one seizure after another without a recovery stage between them. It is extremely dangerous to the individual suffering the seizures, because of the prolonged repetitive pattern of electrical stimulation to the brain. The most common factors that precipitate seizure status include sudden withdrawal of seizure-control medications, fever and infections. This form of seizure can lead to decreasing levels of mental functions, increased amount of neurological impairments or even death.

Fortunately, this type of seizure is uncommon. This information is important to police officers in emphasizing the point that the person with epilepsy must continually receive their medication as prescribed.

- **Absence Seizure** - also known as *petite mal* seizures. These seizures are very short and sometimes are difficult to notice. An absence is a brief stare that lasts for about 10 seconds, during which the person has fluttering of the eyelids and/or lip smacking. The individual loses consciousness or goes blank for a few seconds. These seizures are prevalent in childhood, although they may occur in adults. Several absence seizures may occur within a 24 hour period. Absence seizures are within the category of *generalized* because they initially involve both hemispheres of the brain, thereby resulting in impairment of consciousness.
- **Myoclonic Seizure** - consists of one or more clonic-type jerks while still conscious. These seizures last for about on minute. The person is aware of everything around himself/herself, but has no control over the sudden massive muscle jerks or clusters of jerking movements. Muscle spasms which accompany this type are potentially strong enough to throw a person to the ground.
- **Clonic Seizure** - as mentioned above, it is characterized by the jerking, involuntary muscle contractions that are present in the latter stages of the **tonic-clonic** seizure. With these seizures there is no extension of the limbs, rather very rapid myoclonic activity with motions usually of rather small amplitude and very fast. Clonic seizures may involve the entire body and there is usually a loss of consciousness.
- **Tonic Seizure** - as mentioned above, it is characterized by an extension of the extremities with rigid stretching of the body. The tonic seizure is most common in children and adolescents. The seizure frequently begins with the sound of crying, yet there are essentially no risks. The attack can be severe and often a violent distortion of the head, face and limbs. The head and eyes may deviate, facial muscles contract and posturing of the limbs is prominent.
- **Atonic Seizure** - is better known as the Epileptic Drop Attack. Atonic seizures are characterized by a sudden loss of muscle tone, causing the individual to slumber drop to the floor. Individuals suffering from this type of seizure may be required to where safety gear, such as a posy vest and bike safety helmet.

Responding to Persons During a Seizure Episode

---

overhead - Ensuring Officer Safety

How can officer safety be ensured in situations involving seizures due to epilepsy or other causes?

Officers and criminal justice system personnel should follow standard safety precautions when approaching an unknown situation; however, where there is a possibility that a seizure is the cause of the behavior that is observed, they should:

- stay calm and assert authority to those in the surrounding area
- address the individual in a non-threatening tone to assess level of awareness and response
- look for a medical identification bracelet or necklace stating "epilepsy" or "seizure disorder"
- ask witnesses/bystanders what happened, and whether the individual has had similar episodes in the past or is known to have epilepsy
- guide individual away from hazards and away from crowds when possible, while speaking in a calming, reassuring tone
- remember that the most likely danger in dealing with someone having a seizure is that he/she will strike out aggressively in response to physical restrain.

---

overhead - Symptoms Seen During or Following a *Generalized* Seizure

---

- A cry at the onset caused by air being forced out of the lungs by contracting muscles
- Falling to the ground, stiffening of the body
- Rhythmic muscle contractions of the whole body, which gradually slow and then stop
- Temporary cessation of breathing and possible development of bluish tinge to the skin
- Slow return to consciousness, accompanied by noisy breathing
- Post seizure confusion, fatigue, temporary inability to respond
- Possible belligerence and irritability following the seizure

---

overhead -- Actions to Take During a *Generalized* Seizure

During the seizure the person may fall, become stiff and make jerking movements. The person's complexion may become pale or bluish.

- DO help the person lie down and put something soft under the head.
- DO remove any eyeglasses and loosen any tight clothes.
- DO clear the area of sharp or hard objects.
- DO NOT force anything into the person's mouth.
- DO NOT try to restrain the person as you cannot stop the seizure.

---

overhead - Actions to Take After the *Generalized* Seizure

- DO turn the person to one side to allow saliva to drain from the mouth.
- DO arrange for someone to stay nearby until the person is fully awake.
- DO NOT offer the person any fluid or drink.

Partial Seizures

Partial seizures involve only a part of the brain. They may or may not impair consciousness. Those seizures where consciousness is not impaired throughout the seizure are called *simple* partial seizures. Seizures that involve an impairment of consciousness are called *complex* partial seizures.

- **Simple-Partial Seizure** - is a form of seizure that starts at one extremity of the body, such as an arm or leg, and progressively moves upward to other areas on that side of the body, as more neurons are affected. A Tonic-Clonic seizure may follow the seizure. One type of simple-partial seizure is named the Jacksonian seizure. Jacksonian seizures begin with twitching in one area of the body and may progress in an orderly manner up the extremity and to another area with the potential of one-half of the body displaying clonic activity.
- **Complex-Partial Seizure** - appears as irrational behavior. A person may uncontrollably twitch their arm or leg, smack

their lips, engage in chewing, grimacing, spitting, mumbling, picking at things, rubbing parts of the body (usually the nose) or wander aimlessly. Only a portion of the brain is involved in the seizure. The seizure usually last only a few seconds. The individual is usually conscious during this seizure. Complex partial seizures are the single most common type of seizure experienced by adults.

- **Secondarily Generalized Seizure** - refers to tonic-clonic seizures that result when from the spread of a partial seizure (originating in one area of the brain). These are partial seizures with secondary generalizations. While the manifestations of this type will appear the same as the generalized, they are mentioned only in that different medications are effective for each category.

---

overhead - Symptoms During or Following a *Partial* Seizure

- Starts with a blank stare, followed by chewing or twitching movements of the mouth or face
- Communication becomes blocked or disordered
- May mumble, look dazed, unaware of surroundings and sometimes understand spoken work but be unable to respond
- Actions appear clumsy, not directed, may wander without regard to location or barriers in path, and may make repeated movements with part of the body or fumble with clothing
- Actual seizure lasts a couple of minutes, confusion remains for up to half an hour afterwards
- Less common symptoms may be screaming, crying, moaning, laughing, apparent fear, disrobing, unnatural movements of arms or legs

---

overhead - Actions to Take During a Partial Seizure

- DO try to remove harmful objects from the person's pathway or coax the person away from them.
- DO NOT try to stop or restrain the person.
- DO NOT agitate the person.

- DO NOT approach the person if you are alone and the person appears to be angry or aggressive. This is very unusual.

After the seizure: The person may be confused or disoriented after regaining consciousness and should not be left alone until fully alert.

---

overhead - Seizures and the Need for Medical Attention

- If the person does not start breathing within 1 minute after the seizure ends (begin mouth-to-mouth resuscitation)
- If a generalized tonic-clonic seizure lasts more than 2 minutes.
- If the person has one seizure right after another.
- If the person is injured.
- If the person requests an ambulance.

Differences Between Mental Illness and a Seizure

Mental illness tends to be a constant problem, or changes relatively slowly. People with epilepsy will experience a sudden change from normal to impaired. People who are mentally ill will be able to interact with the officer on some level. During a generalized or complex partial seizure meaningful interaction with an officer, or with anyone else is unlikely. Speech, comprehension and information processing are all affected by seizure activity in the brain.

Differences Between Intoxication and a Seizure

Intoxication has a slow, observable onset. Seizures arise abruptly from a normal state. Intoxicated people will have a strong smell of alcohol present while someone having a seizure may or may not have had an alcoholic drink prior to the seizure. Acknowledgement is also made that seizures can also occur in alcoholic persons. When this is the case, the person should be managed in the same manner by attempting to protect them from injury, and not forcibly apply restraint. Police interactions with an intoxicated person, while impaired by slurred speech, inappropriate behavior and a staggering gait, can take place on some level. Interaction is usually not possible with someone who is having a seizure until the seizure is over. The police should observe for other identification as most persons who have a history of seizures will wear a medical ID bracelet.

Police Involvement

No one chooses to have a seizure, and seizures can strike any person at any time, and without warning. There are no common characteristics of persons with epileptic seizures other than the seizures themselves. This condition can affect the well off, the middle class, and those living on the fringes of society. Where the seizure occurs as well as what it looks like may have an effect on the police's response. The police officer, in approaching a person with seizure-related behavior must respond to the seizure regardless of the circumstances in which it occurred.

To have this condition means that from time to time one's ability to control one's actions and ones link to the surrounding reality is temporarily lost. Control is important to everyone; losing it is humiliating. No member of the community who values his or her reputation wants to appear unable to control his or her movements in a public place. Yet this kind of experience, and the resulting embarrassment, is similar to some seizure episodes. No one need be concerned about being violently attacked by a person who suffers from epilepsy simply because they have seizures. If a person is violent, they should be dealt with in the same manner as a violent person who does not have seizures.

The role of the police officer in the majority of occasions involving persons with epilepsy will be that of a helper rather than an enforcer. Therefore, it is important that officers respond with dignity to calls involving persons with life-long disabling conditions. Most behavior involving a seizure-induced behavior is not disruptive. Because of the fact that most calls will be requiring a helping response, it is recommended to guide the victim of the seizure away from hazardous situations (when the person is mobile). Because there is no way to stop a seizure, the best response is the least response and you should engage in as little physical contact as possible. Ensuring and preserving individual rights are important functions in professional police work.

The most fundamental problem in identifying persons with epilepsy is the fact that too often the symptoms are mistaken for daydreaming or deliberate wrongdoing. If people with epilepsy commit a crime they should be treated the same as any body else. Particular problems arise when people with epilepsy are arrested because of a misinterpretation of what takes place during or immediately after a seizure. They may be unjustifiably arrested for disorderly conduct, drunkenness, creating a public disturbance, or being under the influence of drugs.

The police officer and all other personnel in the criminal justice system need to keep in mind that the person, regardless of whether a crime has been committed, must maintain their

medication schedule. If a person with epilepsy is arrested and placed in custody, they can easily be deprived of his/her anti-epileptic medications resulting in further seizures. This discrimination is largely based on a failure to be informed rather than malice, nonetheless missing the medication can be harmful to the person.

Where and When do Encounters Occur?

Seizures can occur anywhere. Many occur at home in settings that would not led to police interaction. Seizures are more likely to come to the attention of law enforcement when they happen in public facilities such as restaurants, stores, recreation centers, banks, in custody, during questioning, in police cruisers, at the site of an accident or other stressful event, and frequently at homeless shelters.

Encounters can take place at any time during police shifts. Seizures caused by alcoholism or illegal drug use may be more likely to occur during the evening hours. The weekends and holidays are peak periods for seizures because persons have exhausted their medication.

---

overhead - Summary of Key Points

- Don't Panic. The first thing to remember is to remain calm during the episode.
- Keep the seizure victim safe during the seizure.
- Time the seizure. How long did the seizure last? Keeping a record of the length of the seizure, along with recording the characteristics of the seizure, allows the individual and medical staff to check for any changes in the seizure behavior.
- Remove any sharp objects or furniture within reach of the individual.
- Place a pillow under the person's head.
- Stay with the seizure victim. Make sure that the individual comes out of the seizure safely. The person could sustain a serious injury from trauma, or stop breathing

Community Resources for Persons with Epilepsy

Texas has 31 community-based MHMR centers with M-R components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource

when needed. The seasoned officer will know that in most instances involving a seizure no referral to an agency is needed. Officers are cautioned that for prolonged seizures or if injury occurs that the person should be transported to a hospital emergency room.

In addition many communities will have a local chapter of the Epilepsy Foundation of America, Association for Retarded Citizens, Mental Health Association or other appropriate social service agencies. The address of the national office as well is as follows:

The Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785-2267
Local Phone: (301) 459-3700
Toll Free: (800) EFA-1000
Fax: (301) 577-2684

Suggested Activity using the Trainee's Guide:

1. Check your own general knowledge about **epilepsy and seizures** on page 26 and answer the self-check questions on page 27. Compare your answers with the answers on page 29.
2. Role-Playing Activity: Working as a pair, with one partner role playing the part of the officer and the other team member acting the role of the suspect.

Hearing Impairments

Objectives

Performance Objective:

Given a subject with a hearing impairment involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 36 in the Trainee's Guide. Include such factors as general information, identification, communication and community resources.

Enabling Objectives:

1. **Demonstrate your general knowledge of the unique factors of persons with hearing impairments.**
2. **Role play with another participant with hearing impairments in a simulated situation.**

Suggested note to trainer: Ask participants if any of them has ever had an experience encountering a person with a hearing impairment. If someone has, ask them to tell of situation and how they knew the person had a hearing impairment. What were the distinguishing characteristics? Then, present the following incident which is identical to the corresponding role-playing activity in their trainee's guide.

Description of the scene:

As an officer, you respond to a call involving a two-car accident. The drivers were the only passengers in either car and neither were seriously injured. As you arrive, the drivers are accusing each other of being at fault. You inquire if there were witnesses to the accident. It appears that a pedestrian did see the accident and each give a similar description of the person who walked away.

You complete your work at the accident scene and proceed in the direction in which the witness left the scene. You make a routine stop at a popular donut shop and notice a young man that fits the description of the alleged witness of the car accident. You introduce yourself to the person and he appears to be reading your lips and not being very responsive to your questioning. What clue do you have to his disabling condition? Try to communicate with the person, soliciting basic information regarding the car accident.

Identifying the Hearing Impaired

---

overhead - Identifying Persons Who are Hearing Impaired

- The person appears alert but fails to respond to any sounds.
- The person points to the ears, or to the ear and mouth, and might also shake their head.
- The person speaks in a flat or harsh, unintelligible monotone voice.
- In the case of a traffic check, the officer should keep his/her eyes on the person's hands and be aware that the person might be reaching for a pen and pad to write.

Background: Hearing Impairments

A reoccurring theme in the study of life-long disabilities is that attitudes about them can be traced back to ancient and medieval times. Curiosity about persons labeled *deaf* and *dumb* from birth is at the core of ancient inquiries about DD. For centuries, not only the public but eminent scientists of the day held the deaf to be fools who were incapable of learning and possessed of evil.

Man's need to communicate with his fellow man is possibly his greatest uniquely human need. The sense of hearing, the primary means by which infants develop language and speech, serves as the basis of human communication, with its attendant social and intellectual interaction throughout a person's life. Impairment of hearing, whether it be congenital deafness, acquired loss through illness or the gradual loss of hearing in later years, results not only in the primary disability of impaired communication but also the companion disability of the social stigma imposed on the hearing impaired by hearing people.

Only recently were some of the misconceptions gradually eliminated; but many remain as some continue to use the terms *deaf and dumb* and *deaf-mute*. Fortunately, the past two decades have been marked by a remarkable explosion of medical and technological advances in fields that offer assistance to persons with hearing loss, and by the enlightened interest in the educational and sociological betterment of persons with hearing loss.

Review Definitions

---

overhead - Definitions of Impairment ----

Impairment:

A loss of physical or mental functioning at the organ level.

Disability:

When the effect of the impairment is severe enough to inhibit functioning.

Handicap:

> Obstructions imposed by society that inhibit the pursuit of independence.

Early in the first section we set forth definitions of *impairment* and *disability*, as well as *development*. Again, development refers to the period of life when persons are acquiring basic skills. While there are over 40 million persons in the United States with significant hearing impairment, approximately two-thirds of that number represent hearing loss associated with advanced age. This material is about developmental disabilities, or persons who are hearing impaired from birth or the developmental period. The disabilities and handicaps resulting from impaired vision and hearing are often compared as there is no doubt that blindness rates the highest degree of pity and sympathy. Yet, while blindness cuts people off from objects, deafness cuts people off from people. The result is social isolation.

Defining Deafness & Hearing Impairment

The word *deaf* is commonly applied to both partial and complete inability to hear. The term *hard of hearing* is used with a broad stroke of the linguistic brush and frequently alludes to both profound losses that can qualify as legal deafness and to moderate or even mild losses. One can be deaf through inability to hear amplified pure-tone signals above a certain volume or without reference to hearing capacity. A person is considered deaf when they cannot hear enough to recognize sounds or word combinations even when they are amplified. Generally, persons are considered hard of hearing when capable of only partial recognition of the spoken language or if conversation must be close and unusually clear to be understood.

One very important functional difference between the deaf and hard of hearing is that deaf implies the absence of sound. The person who is deaf can rarely follow speech and knows of that limitation. The person who is hard of hearing thinks they can recognize speech with the result frequently being a misunderstanding of what was said. The results may be good for laughter, but also may be yield miscommunication, an inaccurate appearance of sagging intelligence or indifference.

The human ear is very unique. It packs into a space smaller than a lime an electronics system with capabilities approximating as many wires as the telephone system of a city with a population of 300,000, and in many ways is more versatile and reliable than a telephone system. Ears can spot the location of sound, even if it is distant or behind us, despite the fact that we

cannot move our ears as animals do. Ears collect and decipher whispers, sounds of gunfire or help us distinguish one musical note from another.

What Causes Hearing Loss?

Hearing loss can be inherited (genetic), congenital (acquired in the womb) or acquired after birth. The most common form of hereditary loss results in a blockage of the oval window that restricts passage of sound from the middle ear to the inner ear. Other less common hereditary forms are predispositions to auditory nerve degeneration and anatomical malformations. Hereditary deafness is believed to be responsible for approximately one-half of all childhood deafness (Stein, 1988). Persons born with Down syndrome frequently have hearing loss attributable to genetic factors.

Congenital deafness is caused by blood-group incompatibilities of the mother and the fetus and viral infections contracted by the mother during pregnancy. A baby is most likely to be born with hearing problems if the mother suffers an infection during the first three months of pregnancy as all the components of the ear are completely developed during this brief period.

Acquired hearing loss can result from a variety of causes including childhood diseases such as measles and mumps, and assorted viral infections that can cause inflammation of the inner ear. Hearing loss can also be acquired from such day-to-day items such as industrial gases, nicotine or excessive use of aspirin. Excessive noise over a prolonged period can also impact negatively on hearing.

Types of Hearing Disorders

The physiological complexity of the hearing mechanism may be thought of as a device converting sound waves into mechanical energy, then into fluid energy, and finally into electrical energy in the form of nerve impulses. This unique feat is accomplished by the three main parts of the ear: (a) the outer and middle ear mechanism. (b) the inner ear and (c) the central auditory system of the central nervous system.

A hearing disorder involving the outer or middle ear mechanism, the mechanical portion of the system, results in what is termed a *conductive* hearing loss. This type of loss is similar to the volume on the radio being set very low with little or no distortion of sound. Conductive hearing loss results from a blockage or breakdown in the canal, eardrum, or middle ear bones. Hearing tests on people with conductive deafness show the inner ear or nerve function to be normal but the air conduction to be reduced. Persons with conductive hearing loss usually speak very softly because sound generated by their own

voice appears louder owing to direct conduction through the skull into the inner ear. Conductive hearing loss can often be cured by surgery or improved through the use of a hearing aid.

The second major category of disorders involves the inner ear. When the inner ear is affected a *sensory* deafness results, and if the nerve of hearing is involved then a *neural* hearing loss occurs. Usually these two groups are lumped together under the term *sensorineural* (Rosenthal, 1987). Sensorineural hearing loss cannot be cured by surgery or helped by the use of a hearing aid. This type is often likened to a radio with the dial not being properly tuned. Amplification of sound for these persons over amplifies the often normal low frequencies in an effort to improve the high frequency loss and results in a noisy jumble. Another characteristic of sensorineural deafness is that it is quite commonly for the sound, when amplified to become painful. This type of loss can cause one to be irritated by the raspy, fuzzy qualities of any sound (Freeland, 1989). Persons affected often mistake words like *fifty* for *sixty* or *twenty* for *thirty*. Because these persons often become irritated, they frequently "switch off" their concentration.

Another frequently used classification system is:

- Pre-lingual/early onset deafness
  - Refers to persons who were born deaf or became deaf in early childhood.
  - People in this category use sign language as their primary means of communication.
- Post-lingual deafness
  - Persons who belong to this group lose their hearing later in life after learning language.
  - Persons under this category lose their hearing for various reasons.
  - One of these reasons may be age. Many of these people are known as hard of hearing. For this group, it is difficult to generalize the primary means of communication. Many will NOT know sign language, many will have comprehensible speech and most will be unable to lipread.

Prevalence of Hearing Impairments

Hearing loss is frequently described as the nation's number one disabling condition as it affects more Americans than cancer, heart disease, tuberculosis, blindness, multiple sclerosis, venereal disease and kidney disease combined (Stein, 1988). Approximately 50 percent of persons age 75 plus have a significant degree of hearing loss (Stein, 1988). Hearing

impairment, when treated as a developmental disability occurs at the rate of approximately six per 1,000 persons or six-tenths of one percent (.6%). The rates increase as age categories increase. The prevalence rate when all age categories are combined is 7.64 percent.

Additional Disabling Conditions

Additional disabling conditions or secondary problems are estimated to occur in about one-third of persons with severe hearing impairments (Stein, 1988). Conditions that are most frequently reported are mental retardation, perceptual disorders, emotional and behavioral problems and visual impairment. As mentioned earlier, up to 50 percent of persons with Down syndrome have hearing loss attributable to one of the two major types.

Little research has been conducted on adults with hearing impairments and emotional disturbances. Studies on older youth as reported by Stein (1988) indicate that up to one-third have some degree of emotional disturbance. The two most common factors thought to contribute to persons with hearing impairments having emotional problems are: (1) inadequate language development and thus no effective way to communicate and (2) the failure of others to fully understand their condition. The only persons who truly understand the problems faced by deaf persons are other persons who are deaf. Therefore, deaf people are unusual as a disability group in that among themselves they are not disabled. For this reason, they frequently become a culture unto themselves. The deaf community can appear very much like a minority group as they are held together by common experiences (specialized training, share a common way of communicating, jokes, etc.)

Mature persons that are hearing impaired suffer disorders of mental health and mental retardation in proportions similar to the incidence rates within the general population of mature adults. They do appear to have a low tolerance for emotionally demanding situations. Some of the more common symptoms of disturbance for deaf youth are as follows:

---

overhead - Hearing Loss and Emotional Disturbances

- chronic depression
- low frustration tolerance
- over-dependence and compliance
- lack of flexibility
- few social contacts

- unusual withdrawal
- attention-getting behavior
- nervous habits
- inappropriate laughter or silliness
- aggressiveness and potential danger to others

The reaction of the deaf individual to the police officer and society in general is a function of their hearing capacity and educational background. The police officer has no way of knowing these things in their initial contact with the person with a hearing impairment therefore should consider these basic facts:

---

overhead - Basic Facts

- The personalities of persons who are deaf are as unique as the mainstream of society.
  - They are more like you than unlike you.
- The common bond among deaf people is their hearing disability.
  - Deafness is more than just a loss of hearing.
- The real handicap of deafness is being cut off from normal means of acquiring and transmitting language.
  - Communication loss
- This affects a deaf person's sophistication about his/her world and results in personal, social, educational and occupational obstacles. Deaf persons try to cope through auxiliary means of communication such as sign language, lip reading, reading and writing.

Types of Communication

---

overhead - Communicating with a Person -----

- Lipreading - is the least reliable method of communication. Lipreading is about 30% effective in understanding what is being said.
- Reading & writing notes - is an effective means of communication, but you must be patient. A deaf person's grammar might be hard to understand.
- Sign language - is the preferred mode of communication. Ask a nearby friend or family to assist in interpreting. If none is available, have the dispatcher find an interpreter.

As in any situation involving the victim of a crime, one of the police officer's first priorities is to obtain a description of the suspect. With a deaf victim, it is essential to decide on the method of communication immediately. **Lipreading** is the least reliable of the three communication methods. Only about 30 percent of what is said can be lip-read. If the person is able to lip-read, make sure there is adequate light, so the person can see your lips. The officer should look directly at the person when speaking. Be aware that a moustache or using chewing gum makes it more difficult for an individual to read your lips.

Writing notes is often an effective means of communication. The officer should note that the grammar of persons who are deaf is often hard to understand. Writing notes will require patience on the officer's part.

Sign language is the preferred method of communication. This requires the presence of an interpreter. Often there is a family member or friend with these skills that can provide assistance. The police dispatcher should maintain a list of interpreters available in your area.

Police Encounters

---

overhead - Police Encounters with the Hearing Impaired

- Victim of a crime
- Witness to a crime
- Motor aehicle accident
- Traffic checks
- Rights of a deaf suspect

The hearing impaired as a witness.

A deaf **witness** to a crime or an incident may be more helpful than his or her counterpart. Deaf persons may observe more than a hearing person viewing the same event as they are more dependent on visual cues in understanding their environment.

Motor vehicle accident involving a person with a hearing impairment.

The police officer may be called to the scene of an accident involving a person with a hearing impairment. (The transparencies labeled *identification* might alert the officer to the fact that the person has a hearing impairment.)

Traffic checks and persons with hearing impairments.

The police officer's trained response in approaching a traffic

violator is to exercise caution and maintain personal safety. In situations involving a driver with a hearing impairment, it is a normal reaction for the person to instantly reach for a pen and pad located in his/here pocket or glove compartment. Drivers who are deaf are taught that when stopped by the police that they should place their hands on the steering wheel; however, in the anxiety of the moment, the person might fail to remember this procedure.

The rights of a deaf suspect.

The police officer, when dealing with a deaf suspect should exercise caution so as to not intentionally violate his/her civil rights. Many cases involving deaf suspects have been incorrectly handled in the past, resulting in inadmissible evidence. Persons with hearing impairments have a legal right to a professional interpreter. Family members and friends are not professionals. The officer should never attempt to question a person who is hearing impaired without an interpreter. A written Miranda may not be sufficient. The Miranda warning is written at an eighth grade level, while the average deaf person reads at a fifth or sixth grade level. Suspects also have the right to make a telephone call using a telecommunication device for the deaf (TDD).

Communi-cation Tips

---

overhead - Communication Tips for Use with a Person Who is Hearing Impaired

---

Communicating with a deaf person . . .

- Decide on the method of communication immediately (lipreading, writing notes or sign language)
    - If lipreading is chosen, make sure there is adequate light, look directly at the person, and be aware that a moustache or chewing gum makes lipreading difficult.
    - If writing is chosen, remember that a deaf person's grammar is different and might be hard to understand.
    - If sign language is used, find an interpreter
- Be patient.
- Face the deaf person when you speak
- Listen to both sides of the story–deaf persons have noted that police officers tend to ignore them.

Summary

- Every hearing impaired person copes with his or her communication loss in a different way.
- Persons with hearing impairment can be mistaken for persons who are senile, mentally ill or mentally retarded. This problem of identification occurs because people with hearing are unaware of deaf people's communication difficulties. This problem is further compounded by people who are hearing impaired that are unable to ask for better communication.
- It is a state law in Texas that deaf persons be provided with a qualified interpreter involving any governmental procedure (Code of Civil Procedure 1965, (d), Art. 38.31). Under state law, these services are paid for by the governmental body involved in the case.
- You, not the interpreter, are the one talking to the deaf person.

Community Resources for Persons with Hearing Impairments

Texas has 31 community-based MHMR centers with M-R components that employ specialists in the delivery of services to persons with all categories of developmental disabilities. The law enforcement officer should develop a working relationship with at least one person in the closest facility so as to have a resource when needed. The seasoned officer will know that in most instances involving a person with a hearing impairment, no referral to an agency is needed. Officers may consider this agency as a location for a sign language interpreter.

In addition, many communities will have a Deaf Action Center, with other appropriate resources being the Association for Retarded Citizens, Mental Health Association or other appropriate social service agencies. The address of the Texas Commission for the Deaf and Hard of Hearing is:

Texas Comm. for the Deaf and Hard of Hearing
4800 N. Lamar Boulevard, Suite 310
Austin, TX 75756
telephone 512-451-8494
fax 512-451-9316

Suggested Activity using the Learner's Guide:

1. Check your own general knowledge about **hearing impairments** on page 32 and answer the self-check questions on page 33. Compare your answers with the answers on page 35.
2. Role-Playing Activity: Working as a pair, with one partner role playing the part of the officer and the other team member acting the role of the suspect.

References

Alexander, M.A., & Bauer, R.E. (1988). Cerebral Palsy. In V.B. Van Hasselt, P.S. Strain, & M. Hersen (Eds.), *Handbook of developmental and physical disabilities* (pp. 215-226). New York: Pergamon.

American Association on Mental Retardation. (1992). *Mental retardation: Definition, classification, and systems of supports* (9th ed). Washington, DC: AAMR.

Blackman, J.M. (1987). Disorders of Motor Development. In M.L. Wolraich (Ed.), *The practical assessment and management of children with disorders of developmental and learning* (pp. 164-193). Chicago: Year Book Medical.

Freeland, A.P. (1989). *Deafness: The facts.* Oxford: Oxford University.

Gelman, S. R. (1986). Advocacy on behalf of the developmentally disabled offenders. *The Prison Journal,* 66(1), 24-38.

Gillingham, G. (1997). *Autism: Handle with care* (2nd ed). Arlington, TX: Future Education, Inc.

Hermann, B.P., Desai, B.T., & Whitman, S. (1988). Epilepsy. In V.B. Van Hasselt, P.S. Strain, & M. Hersen (Eds.), *Handbook of developmental and physical disabilities* (pp. 247-270). New York: Pergamon.

Holmes, D.L. (1989). The years ahead: Adults with autism. In M.D. Powers (Ed.) *Children with autism: A parents' guide* (pp.253-276). Rockville, MD: Woodbine House.

Janicki, M.P. (1991). *Building the future: Planning and community development in aging and developmental disabilities.* Albany, NY: NY State Office of MR/DD.

Michael, R.J. (1995). *The educator's guide to students with epilepsy.* Springfield, IL: Charles C. Thomas.

Miller, F., & Bachrach, S.J. (1995). *Cerebral Palsy: A complete guide for caregiving.* Baltimore: Johns Hopkins University.

Poelvoorde, R. (1994). *Law enforcement and the disabled.* Springfield, Il: Office of the Secretary of State, State of Illinois.

Reid, D. (1987). Unknowing punishments. *Student Lawyer, 15*(9), 18-23.

Rosenthal, R. (1987). *The hearing loss handbook.* New York: Schocken.

Santamour, M.B., & West, B. (1982). The mentally retarded offender: Presentation of the facts and a discussion of Issues. In M.S. Santamour & P.S. Wilson (Eds.), *The retarded offender* (pp 7-36). New York: Praeger.

Schor, D.P. (1987). Disorders of mental development. In M.L. Wolraich (Ed.), *The practical assessment & management of children with disorders of developmental and learning* (pp.247-268). Chicago: Year Book Medical.

Stone, W.L., & Ousley, P.Y. (1996). Pervasive developmental disorders: Autism. In M.L. Wolraich (Ed.), Disorders of development and learning: A practical guide to assessment and management (pp.379-398) (2nd ed.). St. Louis: Mosby.

Strein, L.K. (1988). Hearing Impairment. In V.B. Van Hasselt, P.S. Strain, & M. Hersen (Eds.), *Handbook of developmental and physical disabilities* (pp. 271-294). New York: Pergamon.

TEACCH. (1996). Autism primer: Twenty questions and answers. Chapel Hill, NC: UNC-CH. (**T**reatment and **E**ducation of **A**utistic and related **C**ommunication Handicapped **CH**ildren).

Texas Planning Council for Developmental Disabilities (1991). *State plan for Texans with developmental disabilities.* Austin, TX: Author.

Travis, J. (1996). What indicators measure police performance? In T.A. Brady's report, *Measuring What Matters,* from the Policing Research Institute, sponsored by the National Institute of Justice.

U.S. Department of Health and Human Services. (1991). *Report to the President: Citizens with mental Retardation and the criminal justice system* (DHHS Publication No. 93-21046). Washington, DC: Author.

Van Bourgondien, M.E. (1987). Pervasive developmental disorders. In M.L. Wolraich (Ed.), *The practical assessment & management of children with disorders of developmental and learning* (pp.326-351). Chicago: Year Book Medical.

TIPS WHEN IDENTIFYING PERSONS WITH DD

- Identification of a person with mild mental retardation is most difficult.
- Persons with mild retardation are streetwise.
- Be familiar with the names of state schools, community based programs, special education programs, group homes and respite programs in your area.
- Know local jargon relevant to group homes.
- The person may not want their disability to be noticed.
- The person may be overwhelmed by police presence.
- The person may be very upset at being detained and/or try to run away.

DEFINITIONS RELATED TO DISABILITY

Impairment:

A loss of physical or mental functioning at the organ level.

Disability:

When the effect of the impairment is severe enough to inhibit functioning.

Handicap:

Obstructions Imposed by society that inhibit the pursuit of independence.

THE IMPACT OF CHRONIC CONDITIONS AND DISABILITIES

- Organ
- Person
- Family
- Society

DEVELOPMENTAL DISABILITY DEFINED

A developmental disability as defined in 1990* means a severe, chronic disability of a person five years of age or older which:

- **is attributable to a mental or physical impairment or combination of mental and physical impairments;**
- **is manifested before the person attains age twenty-two;**
- **is likely to continue indefinitely;**
- **results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and**

DEVELOPMENTAL DISABILITY DEFINED (Con't)

- reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated; except that such term when applied to infants and young children means individuals from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

* The Developmental Disabilities Assistance and Bill of Rights Act of 1990 (Public Law 101-496)

A WAY TO UNDERSTAND WHAT A DEVELOPMENTAL DISABILITY IS:

- A Condition that an individual may have had since birth or childhood,
- Which during adulthood has prevented him or her from being fully socially or vocationally Independent,
- and which continues on into old age.

FOUR MAJOR TYPES OF SKILLS MASTERED DURING THE DEVELOPMENTAL PERIOD

- Gross Motor - such as walking, running, sitting
- Fine Motor - such as picking up small objects
- Communication - capacities needed to understand others and to express oneself
- Social - necessary for interacting with others

DEVELOPMENTAL DISABILITIES ENCOMPASS A VARIETY OF CONDITIONS

- Mental Retardation
- Autism
- Cerebral Palsy
- Epilepsy
- Blindness
- Deafness
- Orthopedic Impairments
- Learning Disabilities
- Other Neurological/Sensory Impairments

CHARACTERISTICS OF PRISONERS WITH DEVELOPMENTAL DISABILITIES

- The majority are male
- The majority are from minority groups
- The majority have mild mental retardation
- Some carry a dual diagnosis of DD along with mental illness
- Some inmates have additional disabling conditions

TIPS - PHYSICAL APPEARANCE

- **Is the individual appropriately dressed for the season?**
- **Does the individual show any physical defect, that is, unusual physical structures?**
- **Does the individual appear *uncomfortable* with his or her body, or is there awkwardness of movement, poor motor coordination in walking, writing or other physical movements?**
- **Does the individual have a slow reaction to such stimuli as questioning?**

TIPS - EDUCATIONAL HISTORY

- Check available records.
- When asking for identification--ask for cards issued by city transportation agencies as these ID's sometimes disclose physical or mental impairments.
- Obtain information from the person while conversing about his or her family and childhood history.
- Is the individual in the proper school grade for his or her age? Two or more grades behind in school is evidence that this may be a retarded person.
- Is the individual in a special education class or vocational class?

TIPS - SPEECH/LANGUAGE PROBLEMS

- Does the person have any obvious speech defects?
- Does the person understand the questions?
- Are there any signs of deafness?
- Can he/she provide appropriate answers?
- Does the person offer parrot responses?
- Does the person understand his/her Miranda rights? Is the person able to explain them in his/her own words?
- Is the person attentive?
- Can he/she apply abstract reasoning?
- Does he/she have limited grammatical skills?
- Are there problems in describing facts or details of offense?

TIPS - SOCIAL BEHAVIOR

- Does the person associate with younger persons?
- Does the person seem to want to please?
- Does the person crowd personal space when interacting with others?
- Is the person's behavior age appropriate?
- Is the person easily persuaded or influenced by others?
- Does the person have an advocate, who assumes responsibility or provides help to the person with mental retardation in certain situations?
- Is the person easily frustrated?
- Does the person avoid questions concerning a disability?

TIPS - PERFORMANCE TASKS

- Identify himself/herself by name
- Read and write (newspaper, their address, etc.)
- Use the telephone, also find their number
- Describe the appearance of someone they know
- Give directions to their home
- Name the first four months of the year
- Repeat five numbers backwards
- Tell time on a regular watch to the minute
- Count to 100 by 10's or 5's
- Define some words; i.e., sympathy, deceased, pharmacy, etc.
- Tell you the date, time, month, year, and city
- Make change: how many dimes are in a dollar, how many nickels in a dollar, etc.
- Does or does not understand directions
- Does or does not use public transportation
- Understands his/her rights upon arrest--that is, the Miranda warnings

TIPS - CRIMINAL HISTORY

- Check records and look for evidence that the person has been involved in criminal activity as a follower.
- Has the individual become involved in illegal activity to gain acceptance from others?
- Is the person noticeably older than the other persons involved?
- Was the individual the initiator of criminal activity? Was the person a follower?
- Did the individual show a greater likelihood of confessing to the crime that he or she was charged with?
- Did the person remain at the scene of the crime, while others ran? Did the person seem confused about whether he/she had been involved in something illegal?

AFTER A DETERMINATION OF M-R

If the officer determines that the person is retarded, what should be done?

- **Notify as soon as possible the person's parents, legal guardian, or those who provide care for the person.**
- **If the above is not possible, the officer should attempt to contact a mental retardation agency for assistance.**
- **If the crime was fairly minor, always try to reach a disposition not involving the criminal justice system. However, the parent/guardian/house counselor should be made aware of the incident and advised to guard against a similar occurrence.**

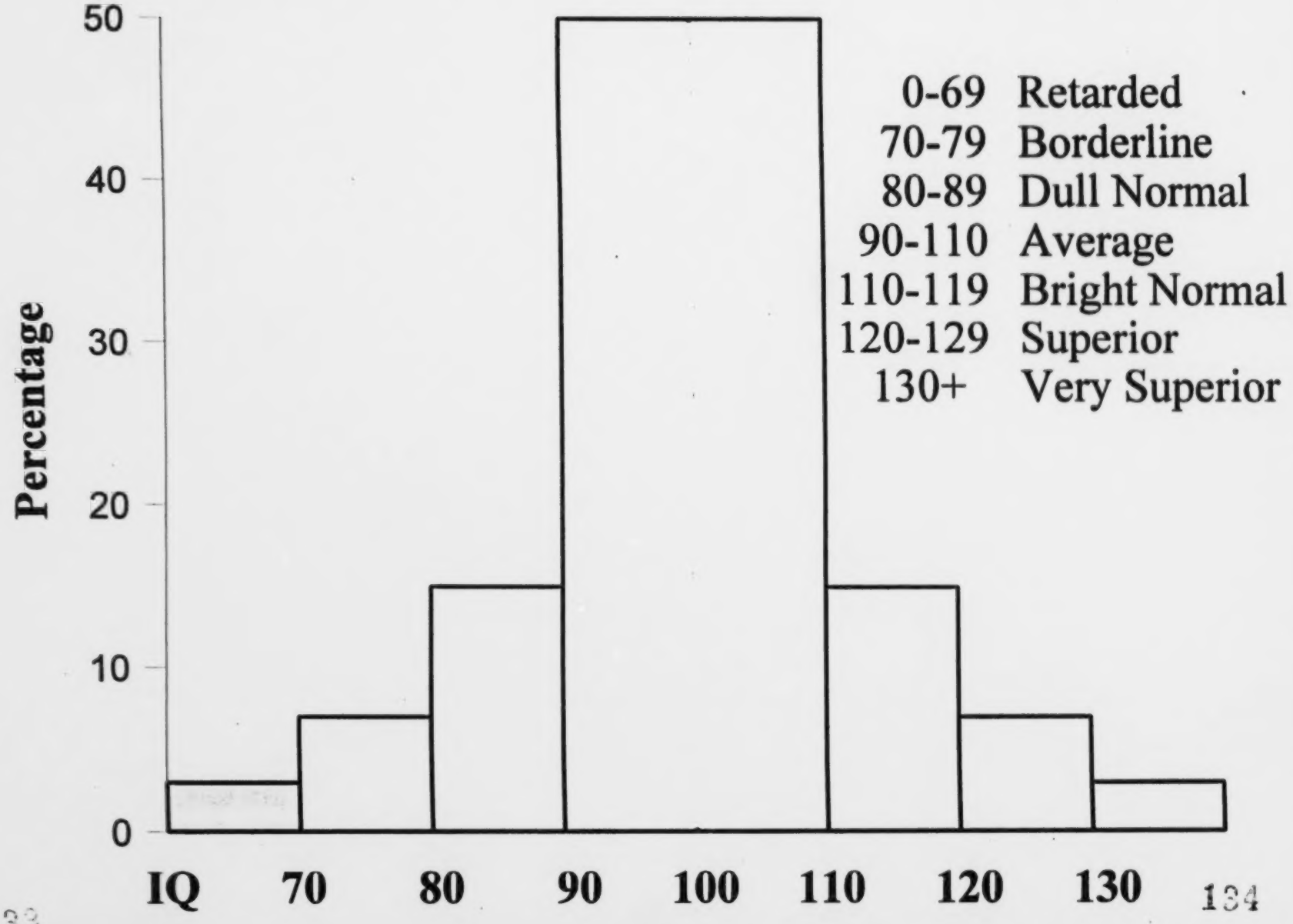
MENTAL RETARDATION DEFINED

Mental retardation **refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work.**

MENTAL RETARDATION
BASIC/WORKING DEFINITION

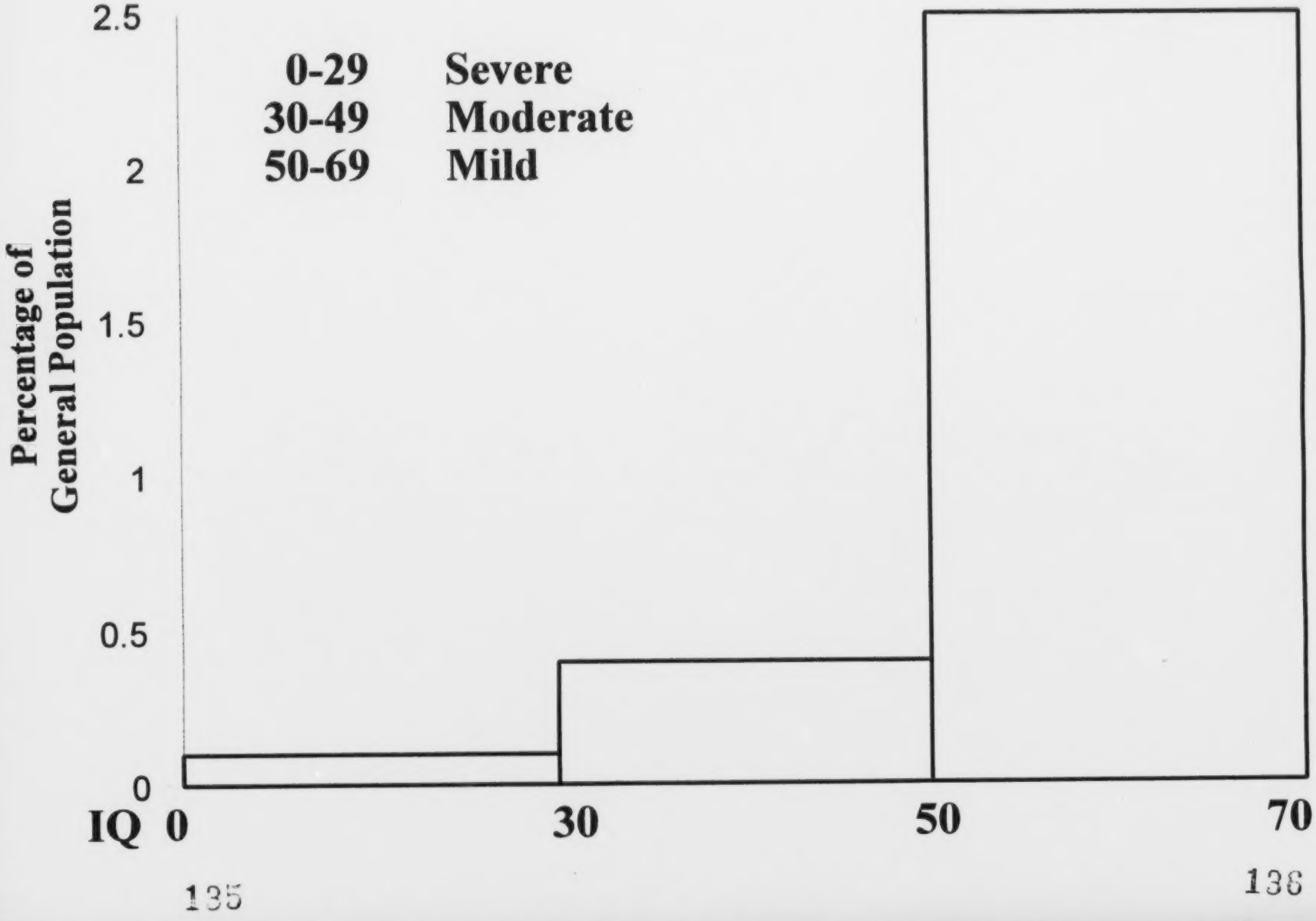
- Significant below average intellectual functioning
- Deficits in adaptive behavioral functioning
- Manifests before the age of 18

CLASSIFICATION OF INTELLIGENCE



0-69	Retarded
70-79	Borderline
80-89	Dull Normal
90-110	Average
110-119	Bright Normal
120-129	Superior
130+	Very Superior

DIVISION OF 3% WITH M-R



FUNCTIONING POTENTIAL OF PERSONS WITH M-R

- Persons who are mildly/moderately retarded
  - Differ from non-retarded persons only in their rate and degree of intellectual development.
  - Should have access to and participate in specialized and generic services in the community.
  - Can live satisfying and productive lives in the community.
  - Usually lose their identity as retarded when employed and are involved in community life.
- Persons who are severely retarded
  - Have a substantially impaired ability to learn.
  - Frequently have disabilities in addition to mental retardation.
  - Have poor judgment and may be subject to exploitation by others.

ADAPTIVE SKILLS

- Communication
- Self-Care
- Home Living
- Social Skills
- Community Use
- Self-Direction
- Health and Safety
- Functional Academics
- Leisure
- Work

POLICE SITUATIONS WITH PERSONS WITH MENTAL RETARDATION

- Victim of a crime
  - Poor judgement leaves one open to suggestions
  - Fail to know when he/she has been victimized
- Witness
  - Have a short attention span
  - Have problems in abstract thinking
- Offender
  - Explore possibilities of keeping out of CJ system
  - Fail to understand consequences of their action
- General Police Contacts
  - Make person feel safe and comfortable
  - Assure the person that you are a friend
  - Use a normal tone of voice, average speech and non-threatening attitude
  - Use patience

OFFICER'S ATTITUDE WHILE INTERVIEWING

- Use an average attitude
- Use a non-threatening attitude
- Be patient
- Take time giving or asking for information.
- Use firm and calm persistence if the person fails to comply or acts aggressive

TIPS WHEN COMMUNICATING WITH PERSON WITH M-R

- **Arrange for a quiet and private setting**
  - **Help the person relax and avoid embarrassment**
  - **Try to make the person feel safe and assure him/her that you are a friend**
  - **Avoid any rapid-fire questions**
- **Speak directly to the person**
  - **Speak slowly and clearly**
  - **Use simple language and vocabulary**
  - **Keep sentences short**
  - **Break complicated series of instructions or information into smaller parts**
  - **If possible, use visual aids**
  - **Use concrete terms**

ADDITIONAL INTERVIEWING TIPS (M-R)

- Repeat and rephrase questions once or twice
- Do not badger the person, it might result in uncooperative behavior
- Ask for concrete descriptions: colors, clothing, etc.
- Avoid confusing questions about reasons for behavior
- Do not ask leading questions
- Ask open-ended questions
- Avoid yes and no questions
- Be aware of the person's reactions to the questions
- Listen carefully to the content of the answer

IDENTIFICATION OF A PERSON WITH AUTISM

General things for police officers to keep in mind as persons with autism exhibit some or all of these symptoms:

- **Uneven patterns of intellectual functioning**
- **May engage in repetitive behavior.**
- **Marked restriction of activity and interests**
- **Touch may be painful - persons with autism do not like to be touched**
- **Persons with autism like a fixed routine**

In criminal justice situations the person with autism:

- **May not understand his/her rights**
- **Difficulty remembering facts or details of offenses**
- **May become anxious in new situations**
- **May not understand consequences of their actions**

CHARACTERISTICS OF AUTISM

- Impaired social relations
- Abnormal language & communication development
- Restricted set of behavioral skills

SOCIAL BEHAVIOR WITH AUTISM

- Lack of awareness of social rules
- Lack of awareness of others - stand-offish
- Poor, unusual or lack of eye contact
- Inappropriate laughing or crying
- Flat facial response - does not match situation
- Trouble with transitions and interruptions
- Resists change in schedule or environment
- Ritualistic behaviors
- Slow to predict consequences
- No fear of real dangers
- Extreme distress for no discernable reason, (e.g., crying tantrums)
- Difficulty mixing with others
- Inappropriate attachments to objects
- Deliberate soiling
- Uneven gross/fine motor skills
- Marked physical over-activity or passivity

COMMUNICATION AND LANGUAGE

- Non-verbal or have very limited verbal abilities
- May appear deaf - may not respond to verbal cues
- May repeat words or phrases
- May have difficulty expressing needs
- Inability to understand
- Impaired pitch, stress, rate, volume, rhythm of speech
- Difficulty with abstract concepts and rational terms
- Indicate needs by gesture
- Generally do not initiate requests
- Pronoun reversals
- Parrots responses
- Quality and quantity of receptive/expressive language is poor

AUTISM AND REPETITIVE ACTIVITIES

Persons with autism may have a preoccupation with:

- **Matching, pairing and ordering objects**
- **Blinking compulsively**
- **Switching lights on and off**
- **Dropping things repetitively**
- **Jumping, rocking, rocking from one foot to another**
- **Hand-shaking**
- **Flicking objects**
- **Chin-tapping**
- **Head-banging**
- **Clapping**
- **Tearing paper**
- **Breaking glass**
- **Spinning things or spinning oneself**
- **Fascination for colored and shiny objects**

PERSONS WITH AUTISM AND SENSORY MODES

- May appear as deaf
- May have fear of sound
- May stare at lights
- May be insensitive to pain
- May dislike contact with textures and people
- May lick and/or smell things

COMMUNICATING WITH PERSONS WITH AUTISM

- Use caution with physical contact
- May have a limited awareness of others
- May be unable to make eye contact
- Persons with autism may parrot responses
- Use simple language, speak slowly and clearly
- Use concrete terms and ideas
- Repeat simple questions
- Proceed slowly
- Do not attempt to physically stop self-stimulating behavior
- They may talk indirectly or look away, and act indifferent
- Use symbols or objects when talking

IDENTIFICATION OF PERSONS WITH CEREBRAL PALSY

- Stiff and jerky movements
- Unsteady and shaky
- Poor balance
- Trouble maintaining upright position
- Random involuntary movements
- Experiences seizures
- Muscle imbalance in one eye (lazy eye)

164

BASIC FACTS ABOUT CP

- CP is not a disease, it is not inherited, it is not contagious, it does not get worse, neither is their a cure

- About 25% of cases result from prenatal causes such as from a virus, unnecessary x-rays, drugs, anemia, lack of proper nutrition, premature delivery

- About 40% of cases are caused by lack of oxygen or an injury during birth or shortly after

- In about 30% of cases the causes are unknown

- Occurs to some degree in about 2.5 out of 1,000 (5 per 2000) live births

C-P CLASSIFICATIONS BY TYPE OF MOVEMENT

- Spasticity - tight limb muscles
- Athetosis - involves purposeless movement
- Rigidity - severe form of spasticity, usually quadriplegic (involving arms and legs).
- Cerebral Ataxia - lack of balance
- Mixed - muscle tone differences

NEUROLOGICAL PROBLEMS THAT MAY BE ASSOCIATED WITH CP

- Seizures and Epilepsy
- Mental Retardation
- Learning Disabilities
- Attention Deficit-Hyperactivity Disorder
- Hydrocephalus
- Behavior Problems
- Visual Impairments
- Hearing Loss
- Speech Impairment
- Swallowing Difficulties

POSSIBLE SECONDARY EFFECTS OF CEREBRAL PALSY

- Poor Nutrition
- Aspiration Pneumonia
- Gastroesophageal Reflux
- Frequent Fractures
- Bladder Control Problems
- Drooling
- Sleep Disorders
- Communication Problems
- Upper Airway Obstruction

IDENTIFYING PERSONS WITH EPILEPSY

In general, people with epilepsy:

- **are indistinguishable until seizure occurs**
- **as intelligent, perceptive and articulate as any other member of the public**
- **are employed and maintain the same kind of social and familial relationships as other people**
- **are unable to interact with other people or to respond appropriately to the environment during a seizure**
- **may have other mental & physical disabilities including mental retardation, cerebral palsy, autism or mental illness**

FACTS ON EPILEPSY

- There are over 2.6 million Americans with Epilepsy
- There are about 125,000 new cases of epilepsy that occur each year
- Most individuals with epilepsy can be helped with medications
- There are over 20 kinds of seizures associated with epilepsy
- One of the most significant problems associated with epilepsy is people's attitudes
- Everyone maintains a certain degree of susceptibility to seizures
- There are over 300,000 students with epilepsy in schools in the U.S.

CLASSIFICATION OF SEIZURES

Generalized Seizures

- Tonic-Clonic (grand mal)
- Absence (petit mal)
- Tonic
- Myoclonic
- Clonic
- Atonic

Partial Seizures

- Simple-Partial Seizures (consciousness not impaired
  With motor signs (Jacksonian)
  With somatosensory and special sensory signs
  With automatic signs
  With psychi symptoms
- Complex-Partial Seizures (consciousness impaired)
  Simple-Partial onset followed by impaired consciousness
  Impaired consciousness at onset
  Secondarily Generalized (partial onset evolving to generalized tonic-clonic seizures)

TIPS TO ENSURE OFFICER SAFETY WHEN INVOLVED WITH PERSON DURING A SEIZURE EPISODE

- Follow standard safety precautions
- Stay calm and assert authority in surrounding area
- Address the individual in a non-threatening tone to assess level of awareness and response
- Look for a medical identification bracelet
- Ask witnesses/bystanders what happened and whether the individual has had similar episodes
- Guide individual away from hazards and crowds
- Remember that the most likely danger in dealing with someone having a seizure is that he/she will strike out aggressively in response to physical restrain

SYMPTOMS SEEN DURING OR FOLLOWING A GENERALIZED SEIZURE

- A cry at the onset caused by air being forced out of the lungs by contracting muscles
- Falling to the ground, stiffening of the body
- Rhythmic muscle contractions of the whole body, which gradually slow and then stop
- Temporary cessation of breathing and possible development of bluish tinge to the skin
- Slow return to consciousness, accompanied by noisy breathing
- Post seizure confusion, fatigue, temporary inability to respond
- Possible belligerence and irritability following the seizure

ACTIONS TO TAKE DURING A GENERALIZED SEIZURE

During the seizure: The person may fall, become stiff and make jerking movements. The person's complexion may become pale or bluish.

- **DO help the person lie down and put something soft under the head.**
- **DO remove any eyeglasses and loosen any tight clothes.**
- **DO clear the area of sharp or hard objects.**
- **DO NOT force anything into the person's mouth.**
- **DO NOT try to restrain the person as you cannot stop the seizure.**

ACTIONS TO TAKE AFTER THE GENERALIZED SEIZURE

- **DO turn the person to one side to allow saliva to drain from the mouth.**
- **DO arrange for someone to stay nearby until the person is fully awake.**
- **DO NOT offer the person any fluid or drink.**

SYMPTOMS SEEN DURING OR FOLLOWING A PARTIAL SEIZURE

- Starts with a blank stare, followed by chewing or twitching movements of the mouth or face
- Communication becomes blocked or disordered
- May mumble, look dazed or unaware of surroundings, and sometimes understands spoken word but be unable to respond
- Actions appear clumsy, not directed, may wander without regard to location or barriers in path, and may make repeated movements with part of the body or fumble with clothing
- Actual seizure lasts a couple of minutes; confusion remains for up to half an hour afterwards
- Less common symptoms may be screaming, crying moaning, laughing, apparent fear, disrobing, unnatural movements of arms or legs

ACTIONS TO TAKE DURING A PARTIAL SEIZURE

- **DO try to remove harmful objects from the person's pathway or coax the person away from them.**
- **DO NOT try to stop or restrain the person.**
- **DO NOT agitate the person.**
- **DO NOT approach the person if you are alone and the person appears to be angry or aggressive. This is very unusual.**

After the seizure: **The person may be confused or disoriented after regaining consciousness and should not be left alone until fully alert.**

SEIZURES AND THE NEED FOR MEDICAL ATTENTION

- If the person does not start breathing within 1 minute after the seizure ends begin mouth-to-mouth resuscitation.
- If a generalized tonic-clonic seizure lasts more than 2 minutes.
- If the person has one seizure right after another.
- If the person is injured.
- If the person requests an ambulance.

SUMMARY OF KEY POINTS

- **Don't Panic: The first thing to remember is to remain calm during the episode.**
- **Keep the seizure victim safe during the seizure.**
- **Time The Seizure: How long did the seizure last? Keeping a record of the length of the seizure, along with recording the characteristics of the seizure, allows the individual and medical staff to check for any changes in the seizure behavior.**
- **Remove any sharp objects or furniture within reach of the individual.**
- **Place a pillow under the person's head.**
- **Stay with the Seizure Victim. Make sure that the individual comes out of the seizure safely. The person could sustain a serious injury from trauma or stop breathing.**

IDENTIFYING PERSONS WHO ARE HEARING IMPAIRED

- The person appears alert but fails to respond to any sounds.
- The person points to the ears, or to the ear and mouth, and might also shake their head.
- The person speaks in a flat or harsh unintelligible monotone voice.
- In the case of a traffic check, the officer should keep his/her eyes on the person's hands and be aware that the person might be reaching for a pen and pad to write.

DEFINITIONS RELATED TO DISABILITY

Impairment:

A loss of physical or mental functioning at the organ level.

Disability:

When the effect of the impairment is severe enough to inhibit functioning.

Handicap:

Obstructions Imposed by society that inhibit the pursuit of independence.

WHEN AND WHERE DO POLICE ENCOUNTERS OCCUR?

- Victim of a Crime
- Witness to a Crime
- Motor Vehicle Accident
- Traffic Checks
- Rights of a Deaf Suspect

COMMUNICATING WITH A PERSON WITH HEARING IMPAIRMENT

- **Lipreading - is the least reliable method of communication. Lipreading is about 30% effective in understanding what is being said.**

- **Reading & writing notes - writing is an effective means of communication, but you must be patient. A deaf person's grammar might be hard to understand.**

- **Sign language - is the preferred mode of communication. Ask a nearby friend or family to assist in interpreting. If none is available, have the dispatcher find an interpreter.**

COMMUNICATION TIPS FOR USE WITH PERSONS WITH HEARING IMPAIRMENTS

- Decide immediately on the method of communication (lipreading, writing notes or sign language).
  - If lipreading is chosen, make sure there is adequate light, look directly at the person, and be aware that a moustache or chewing gum makes lipreading difficult.
  - If writing is chosen, remember that a deaf person's grammar is different and might be hard to understand.
  - If sign language is used, find an interpreter.
- Be patient.
- Face the deaf person when you speak.
- Listen to both sides of the story--deaf persons have noted that police officers tend to ignore them.

Sensitizing Law Enforcement Officers to Persons with Developmental Disabilities

A Course Developed

by

Donald R. Louis, Ph.D.
Rosalva Resendiz, M.A.

LAW ENFORCEMENT OFFICER'S TRAINEE'S GUIDE

Course/Program Title:

THE CRIMINAL JUSTICE SYSTEM AND PERSONS WITH DEVELOPMENTAL DISABILITIES: ADVANCED TRAINING

Duty:

SENSITIZING LAW ENFORCEMENT OFFICERS TO PERSONS WITH DEVELOPMENTAL DISABILITIES

Task/Competency: **Resolve an incident involving a person with a Developmental Disability**

Introduction: Changing models in policing and in the care of persons with developmental disabilities (DD) are dual forces mandating that law enforcement officers be able to better understand members of this sub-population. A developmental disability refers to a disabling condition present since birth or the early developmental period.

Performance Objective: Given a subject with DD (mental retardation, autism, cerebral palsy, epilepsy, hearing impaired) involved in a problem situation, demonstrate your understanding of persons with DD according to the information you have been given and by to the standards on page 6.

Enabling Objectives:

1. Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with a developmental disability.
2. Role play with another participant focusing on the special characteristics of persons with DD.

Prerequisites: Completion of basic law enforcement training.

LEARNING EXPERIENCES

Enabling Objective: Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with DD.

Learning Activities	Special Instructions
Listen to lecture on DD. Read/review case study that is provided. Watch video entitled: *Officers Guide: Interacting with Disabled People* Read the KEY POINTS that contain basic knowledge about DD. Demonstrate your knowledge of persons of this sub-population by completing the self-check on page 3; check your answers with those on page 4.	

KEY POINTS

Developing Basic Background Information On Developmental Disabilities

This section is to assist in developing a basic knowledge of why persons with DD are in the community and who are the basic care-givers.

- Different categories of DD require differing techniques in initial contacts.
- A wide-range of possible situations exist with persons with DD and that the majority of confrontations do not involve a crime.
- There is a wide discrepancy between chronological age and intellectual development.
- A developmental disability is generally present from birth.
- There is a wide range of severity of each disabling condition.
- The word developmental, in this context generally, infers a limitation the person has in exercising full control over his/her life.
- A developmental disability may or may not imply mental retardation.
- A developmental disability may be accompanied with reduced adaptive skills.

- People have *disabilities*, not *handicaps*.
- Persons with DD are no more likely to commit a crime than anyone else.
- Persons with DD are frequently manipulated by their non-disabled peers.
- Persons with life-long disabilities may be overwhelmed by the presence of police officers.
- Physical appearance tells little, yet appropriate dress offers a better clue to a person's social skill.
- Speech fluency along with the time involved in responding to questions can provide valuable information.
- Persons with DD frequently do not want their disability noticed and avoid questions concerning their limitations.
- Be sensitive to the dignity of the person
- Do not assume that someone with a developmental disability is totally incapable of understanding or communicating.
- Treat adults as adults, don't treat adults with DD as children.
- Give the same amount of respect to a person with a developmental disability that you would give to any other person.
- Remember that a person with DD is more like you than unlike you.

SELF-CHECK

Directions: Check your basic background knowledge about DD by responding to the following statements. Write "T" (for true) in front of each statement that is correct and "F" (for false) in front of each statement that is incorrect. Check your answers on the next page.

_____ 1. Persons with DD have a thorough understanding of their legal rights.
_____ 2. Persons with DD represent approximately 30% of the population.
_____ 3. Persons with DD never have over-lapping disabling conditions.
_____ 4. Persons with DD have a greater inclination to commit crimes than non-disabled persons.
_____ 5. The number of persons incarcerated with DD is the same as for the non-disabled population.
_____ 6. Persons with DD may be easily frustrated.
_____ 7. Persons with DD tend to over-comply with the requests of others, i.e., plead guilty to crimes they might have not committed.
_____ 8. All persons with DD are mentally retarded.
_____ 9. Many persons with DD are employed.
_____ 10. Persons with DD are easily detected by visual clues.

ANSWERS TO SELF-CHECK

1. false	2. false	3. false	4. false	5. false
6. true	7. true	8. false	9. true	10. false

LEARNING EXPERIENCES

Enabling Objective: Role play with another participant focusing on the special characteristics of a person with a developmental disability.

Learning Activities	Special Instructions
If possible, listen to remarks of one person with a developmental disability that has experienced a confrontation with the police. Role play with another participant using the basic knowledge that you have just received. Read the *KEY POINTS*— listed on page 2-3. Demonstrate your basic knowledge by completing the self-check on page 3. Arrange with your instructor to complete this section of the learning guide by going through the performance test as per the standards on page 6 using the scene developed below.	

Role Playing Activity

Description of the scene:

As an officer, you arrive at a park in response to a call concerning the strange behavior of a young male. You encounter a male, approximately 30 years of age. Although the weather is quite warm, he is dressed in heavy clothes, an overcoat and a scarf. The man is following an older woman, asking her questions typical of those a child might ask. The woman is obviously bothered, and tries to brush him off, but he continues to ask questions, such as, "have you seen my friend Bob?"

You observe the behavior, and question the young man. His answers are simple and stated in the manner of a child. His speech is slightly impaired. The young man explains, rather slowly, that he came to the park to play and has lost his friend. He also explains that he has been asking all the ladies in the park if they have seen his friend. You are asked to resolve the situation. Given the information from this class at this point, attempt to determine if a crime has been committed and identify if the person has a life-long disability. Try to communicate with the person, soliciting basic information, and determine if there is a need for additional community resources. How do you resolve the incident?

PERFORMANCE TEST

Participant's Name:	**Date:**

Competency:	Resolve an incident using basic knowledge of persons with DD.	Test Attempt 1st 2nd 3rd

Directions:	**Overall Evaluation**	
Using information from the case study provided above, complete the following activity per the performance standards listed on page 6.	**Level Achieved**	**Performance Levels**
		4. Can perform this skill without supervision and with initiative and adaptability to problem situations.
		3. Can perform this skill satisfactorily without assistance or supervision.
		2. Can perform this skill satisfactorily, but requires some assistance and/or supervision.
		1. Can perform parts of this satisfactorily, but requires considerable assistance and/or supervision.
	Instructor will initial level achieved.	

PERFORMANCE STANDARDS

Performance Standards For acceptable achievement, all items should receive a *yes* or *N/A* response	Yes	No	Not Appl.
When Approaching			
1. Greeted person with proper body language.			
2. Approached person with caution: a. observed for dress/physical appearance; b. observed adaptive behavior; c. observed for degree of life-threatening conditions.			
Interviewing/questioning person			
3. Used the following skills: a. spoke slowly b. used simple sentences c. asked appropriate questions d. re-used some questions at various intervals			
Family, neighbors and other witnesses			
4. Gathered additional information from: a. family members b. neighbors c. other witnesses			
Closure			
5. Resolved condition for which you were called to respond a. took subject into custody b. counseled with family members regarding alternatives c. referred to appropriate community resources			
6. Filed report a. completed written report by end of shift b. checked with family members within two day period of initial call			

Task/Competency: **Resolve an incident involving a person with mild Mental Retardation.**

Introduction: Changing models in policing and in the care of persons with developmental disabilities (DD) are dual forces mandating that law enforcement officers be able to better understand members of this sub-population. A developmental disability refers to a disabling condition present since birth or the early developmental period.

Performance Objective: Given a subject with **mental retardation** involved in a problem situation, demonstrate your understanding of persons with mental retardation according to the information you have been given and by the standards on page 12.

Enabling Objectives:

1. Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with mental retardation.
2. Role play with another participant focusing on the special characteristics of persons with mental retardation.

Prerequisites: Completion of basic law enforcement training.

LEARNING EXPERIENCES

Enabling Objective: Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with M-R.

Learning Activities	Special Instructions
Listen to lecture on mental retardation. Watch videos entitled: 1. *Officers Guide: Interacting with Disabled People* 2. *Making Contact: Communicating with Adults with Mental Retardation* Read the page entitled *KEY POINTS* that contains basic knowledge about mental retardation. Demonstrate your knowledge of persons of this sub-population by completing the self-check on page 9.	

KEY POINTS

Developing Basic Background Information On Mental Retardation

This section is to assist in developing a basic knowledge which will provide an additional tool when responding to a call involving a person with mental retardation.

- Different categories of DD require differing techniques in initial contacts.
- A range of possible situations exist with persons with mental retardation, and the majority of confrontations do not involve a crime. The typical encounter will require the police to be a helper rather than an apprehender.
- There is a wide discrepancy between chronological age and intellectual development.
- Persons with M-R are no more likely to commit a crime than anyone else.
- Persons with mental retardation comprise about 3% of the general population.
- The majority of persons with mental retardation are in the mild category.
- Mental retardation is usually accompanied with reduced adaptive skills.
- Persons with mental retardation have poor recall of time of day and sequence of events.
- Genetics is only a minor contributor to mental retardation.
- Persons with mental retardation tend not to be violent.
- Persons with mental retardation are subject to being exploited by others.
- Most delinquent acts committed by persons with M-R are the result of inferior social skills.
- A basic principle used in interviewing a person with M-R is to exercise patience.
- Educational history provides insights into the identification process.
- Vocabulary level and grammar usage are good identification clues.
- Observe the age level of the friends of the person with M-R.
- Basic performance tasks provide excellent information such as ability to give directions to their home, or awareness of date, time, month, year and city where they live.
- Remember that their mental age is less than their chronological age .
- Remember that persons with M-R might not understand their Miranda rights.
- Be aware that a person with M-R attempts to please others. Therefore, in a criminal justice situation, the person with M-R might take responsibility for a crime that they have not committed.
- Persons with developmental disabilities do not like being called "retarded" or even have the word "retardation" used in reference to their disability. Use the phrase "person with a disability."
- Remember that a person with a disability is more like you than unlike you.
- A person with M-R is sensitive to your actions and speech.
- Do not assume that a person with M-R is totally incapable of understanding or communicating.

SELF-CHECK

Directions: Check your basic background knowledge about Mental Retardation by responding to the following statements. Write "T" (for true) in front of each statement that is correct and "F" (for false) in front of each statement that is incorrect. Check your answers at the bottom of page 11.

_____ 1. Persons with M-R have a thorough understanding of their legal rights.

_____ 2. Persons with M-R represent approximately 30% of the population.

_____ 3. Persons with M-R never have over-lapping disabling conditions.

_____ 4. Persons with M-R have a greater inclination to commit crimes than non-disabled persons.

_____ 5. The number of persons incarcerated with M-R is the same as for the non-disabled population.

_____ 6. Persons with M-R have poor recall of time of day and sequence of events.

_____ 7. *Mild* is the largest category of persons with mental retardation.

_____ 8. Genetics is the single largest contributor to mental retardation.

_____ 9. Persons with M-R have a good grasp of abstract ideas.

_____ 10. Rapid-fire questions are the best method of questioning a person with M-R.

_____ 11. It is a good practice to repeat questions at various intervals.

_____ 12. *Yes* and *no* type questions are superior to *open-ended* questions.

_____ 13. Adaptive behavioral functioning refers to one's ability in adapting to his/her environment.

_____ 14. Persons with M-R should not be used as witnesses.

_____ 15. It is possible that a person with M-R fails to understand a criminal act that he/she commits.

LEARNING EXPERIENCES

Enabling Objective:	Role play with another participant focusing on the special characteristics of persons with mental retardation.
Learning Activities	**Special Instructions**
If possible, listen to remarks of one person with mental retardation that has experienced a confrontation with the police. Role play with another participant using the basic knowledge that you have just received. Read the *KEY POINTS* listed on page 8. Demonstrate your basic knowledge by completing the self-check on page 9; check your answers with the answers at the bottom of page 11. Arrange with your instructor to complete this section of the learning guide by going through the performance test as per the standards on page 12 using the scene developed below.	

Role Playing Activity

Description of the scene:

As an on-duty officer, you are responding to a call at a shopping mall. The store manager of toys store believes that a middle-aged man has just engaged in shop-lifting and is still in the store. You are told that the suspect has put a small piece of merchandise in his pocket. You approach the suspect, introduce yourself and ask initial questions. The suspect has difficulty in answering your questions and begins crying at a low-intensity. You observed that he has a limited vocabulary which suggests to you that his conditions is mental retardation. Proceed with the interview while utilizing some of the performance tasks that you just learned about. If you detect mental retardation, how will you resolve the incident?

PERFORMANCE TEST

Participant's Name:	Date:

Competency:	Resolve an incident using basic knowledge of persons with M-R.	Test Attempt 1st 2nd 3rd

Directions:

Using information from the case study provided, complete the following activity per the performance standards listed on page 12.

Overall Evaluation	
Level Achieved	**Performance Levels**
	4. Can perform this skill without supervision and with initiative and adaptability to problem situations.
	3. Can perform this skill satisfactorily without assistance or supervision.
	2. Can perform this skill satisfactorily but requires some assistance and/or supervision.
	1. Can perform parts of this satisfactorily, but requires considerable assistance and/or supervision.
Instructor will initial level achieved.	

ANSWERS TO SELF-CHECK

1. false	2. false	3. false	4. false	5. false
6. true	7. true	8. false	9. false	10. false
11. false	12. true	13. false	14. true	15. true

PERFORMANCE STANDARDS

Performance Standards For acceptable achievement, all items should receive a *yes* or *N/A* response	Yes	No	Not Appl.
When Approaching			
1. Greeted person with proper body language.			
2. Approached person with caution: a. observed for dress/physical appearance; b. observed adaptive behavior; c. observed for degree of life-threatening conditions.			
Interviewing/questioning person			
3. Used the following skills: a. spoke slowly b. used simple sentences c. asked appropriate questions d. re-used some questions at various intervals			
Family, neighbors and other witnesses			
4. Gathered additional information from: a. family members b. neighbors c. other witnesses			
Closure			
5. Resolved condition for which you were called to respond a. took subject into custody b. counseled with family members regarding alternatives c. referred to appropriate community resources			
6. Filed report a. completed written report by end of shift b. checked with family members within two day period of initial call			

Task/Competency: Resolve an incident involving a person with Autism.

Introduction: Changing models in policing and in the care of persons with developmental disabilities (DD) are dual forces mandating that law enforcement officers be able to better understand members of this sub-population. A developmental disability refers to a disabling condition present since birth or the early developmental period.

Performance Objective: Given a subject with **autism** involved in a problem situation, demonstrate your understanding of persons with autism according to the information you have been given and by the standards on page 18.

Enabling Objectives:

1. Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with autism.
2. Role play with another participant focusing on the special characteristics of persons with autism.

Prerequisites: Completion of basic law enforcement training.

LEARNING EXPERIENCES

Enabling Objective: Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with **autism**.

Learning Activities	Special Instructions
Listen to lecture on AUTISM. Read the *KEY POINTS* listed on page 14. Demonstrate your basic knowledge of persons with autism by completing the self-check on page 15.	

KEY POINTS

Developing Basic Background Information On Autism

This section is to assist in developing a basic knowledge which will provide an additional tool when responding to a call involving a person with autism.

- Remember that different categories of DD require differing techniques in initial contacts.
- Keep in mind that a range of possible situations exist with persons with autism and that the majority of confrontations do not involve a crime.
- Additionally, there may be a wide discrepancy between chronological age and intellectual development.
- Persons with autism are no more likely to commit a crime than anyone else.
- The majority of persons with autism are oversensitive to stimuli produced by at least one of the sensory organs (sound, smell, touch).
- Autism is usually accompanied with reduced adaptive skills.
- Persons with autism tend not to make eye contact.
- Repetitive behavior is a signal of sensory overload.
- Persons with autism have a limited attention span.
- Persons with autism have difficulty switching attention from one subject to another.
- Persons with autism tend to focus on specific aspects of an object and not see the entire picture.
- Police officers should repeat the first one or two sentences after beginning a conversation.
- Police officers or anyone should not try to stop self-stimulating behavior.
- Persons with autism may parrot the responses of others.
- Persons with autism may use a stand-offish manner.
- Persons with autism have severe delays in language development.
- Persons with autism do not like to be touched. Touch is pain.
- Persons with autism may not understand their rights.
- Persons with autism may have difficulty remembering facts or details of offenses.
- Persons with autism may become anxious in new situations.
- Persons with autism may not understand the consequences of their actions.
- Persons with autism may have impaired social behavior, impaired language skills, sensory impairments and may have a fascination for repetition.
- Autism is found more frequently in men.

SELF-CHECK

Directions: Check your basic background knowledge about **Autism** by responding to the following statements. Write "T" (for true) in front of each statement that is correct and "F" (for false) in front of each statement that is incorrect. Check your answers on page 17.

_____ 1. Persons with Autism have a thorough understanding of their legal rights.

_____ 2. Persons with Autism represent approximately 10% of the population.

_____ 3. Persons with Autism never have over-lapping disabling conditions.

_____ 4. Persons with Autism have a greater inclination to commit crimes than non-disabled persons.

_____ 5. Genetics is the single largest contributor to autism.

_____ 6. Persons with autism are subject to sensory overload.

_____ 7. A typical response to sensory overload is to smile.

_____ 8. Persons with autism can readily switch from one subject to another.

_____ 9. It is best to stop self-stimulating behavior.

_____ 10. Persons with autism may be anxious in new environments.

_____ 11. Persons with autism enjoy eye contact.

_____ 12. All persons with autism have sub-average intelligence.

_____ 13. Persons with autism may appear deaf and not respond to verbal cues.

_____ 14. Repetitive behavior is a signal of contentment.

_____ 15. The basic rule of communication is to use simple language and speak slowly.

LEARNING EXPERIENCES

Enabling Objective:	Role play with another participant focusing on the special characteristics of persons with **Autism**.
Learning Activities	**Special Instructions**
If possible, listen to remarks of one person with autism that has experienced a confrontation with the police. Role play with another participant using the basic knowledge that you have just received. Read the *KEY POINTS*— listed on page 14. Demonstrate your basic knowledge by completing the self-check on page 15; check your answers with the answers at the bottom of page 17. Arrange with your instructor to complete this section of the learning guide by going through the performance test as per the standards on page 18 using the scene developed below.	

Role Playing Activity

Description of the scene:

It is on a weekend morning and you, as an officer on duty, are asked to respond to a 911 call. Upon arriving at the address, you are met at the door by the attendant of a group home housing persons with developmental disabilities. The female attendant tells you that one of the respite residents (there only for an extended weekend) is behaving in a peculiar manner. She states that she only works part-time, and this young man has never been here before. She believes that the tantrum-like mannerisms began when she tuned the radio to some hard-rock music. The music is blaring in the background, and it is further observed that there is a broken vase on the floor.

Based on what you have just learned, how would you attempt to assist the attendant? What category of developmental disability do you suspect this to be, and what contributed to the young man having a tantrum?

PERFORMANCE TEST

Participant's Name:	**Date:**

Competency: Resolve an incident using basic knowledge of persons with **autism.**	Test Attempt 1st 2nd 3rd

Directions:

Using information from the case study provided, complete the following activity per the performance standards on page 18.

Overall Evaluation	
Level Achieved	**Performance Levels**
	4. Can perform this skill without supervision and with initiative and adaptability to problem situations.
	3. Can perform this skill satisfactorily without assistance or supervision.
	2. Can perform this skill satisfactorily, but requires some assistance and/or supervision.
	1. Can perform parts of this satisfactorily, but requires considerable assistance and/or supervision.
Instructor will initial level achieved.	

ANSWERS TO SELF-CHECK

1. false	2. false	3. true	4. false	5. false
6. true	7. false	8. false	9. false	10. true
11. false	12. false	13. true	14. false	15. true

PERFORMANCE STANDARDS

Performance Standards For acceptable achievement, all items should receive a *yes* or *N/A* response	Yes	No	Not Appl.
When Approaching			
1. Greeted person with proper body language.			
2. Approached person with caution: a. observed for dress/physical appearance; b. observed adaptive behavior; c. observed for degree of life-threatening conditions.			
Interviewing/questioning person			
3. Used the following skills: a. spoke slowly b. used simple sentences c. asked appropriate questions d. re-used some questions at various intervals			
Family, neighbors and other witnesses			
4. Gathered additional information from: a. family members b. neighbors c. other witnesses			
Closure			
5. Resolved condition for which you were called to respond a. took subject into custody b. counseled with family members regarding alternatives c. referred to appropriate community resources			
6. Filed report a. completed written report by end of shift b. checked with family members within two day period of initial call			

Task/Competency: **Resolve an incident involving a person with Cerebral Palsy.**

Introduction: Changing models in policing and in the care of persons with developmental disabilities (DD) are dual forces mandating that law enforcement officers be able to better understand members of this sub-population. A developmental disability refers to a disabling condition present since birth or the early developmental period.

Performance Objective: Given a subject with **cerebral palsy** involved in a problem situation, demonstrate your understanding of persons with cerebral palsy according to the information you have been given and by the standards on page 24.

Enabling Objectives:

1. Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with cerebral palsy.
2. Role play with another participant focusing on the special characteristics of persons with cerebral palsy.

Prerequisites: Completion of basic law enforcement training.

LEARNING EXPERIENCES

Enabling Objective:	Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with **cerebral palsy**.
Learning Activities	**Special Instructions**
Listen to lecture on CEREBRAL PALSY. Watch videos: 1. *Officer's Guide: Interacting with Disabled People* 2. *Making Contact: Communicating with Adults with Mental Retardation* Read the page entitled *KEY POINTS* that contains basic knowledge about cerebral palsy. Demonstrate your knowledge of persons of this sub-population by completing the self-check on page 21.	

KEY POINTS

Developing Basic Background Information On Cerebral Palsy

This section is to assist in developing a basic knowledge which will provide an additional tool when responding to a call involving a person with cerebral palsy.

- Remember that different categories of DD require differing techniques in initial contacts.
- Keep in mind that a range of possible situations exist with persons with cerebral palsy and the majority of confrontations do not involve a crime.
- Persons with cerebral palsy are no more likely to commit a crime than anyone else.
- The word *palsy* means a disorder of movement.
- CP is a static, non-progressive disorder of movement and posture due to injuries of the brain sustained during the early developmental period.
- Persons with CP have damage to the area of their brain that controls muscle tone.
- CP is not temporary, and it does not get worse.
- About 25% of cases result from prenatal causes such as from a virus, unnecessary x-rays, drugs, anemia, lack of proper nutrition or premature delivery.
- About 40% of cases are caused by lack of oxygen or an injury during birth or shortly after.
- About 30% of the causes are unknown.
- CP occurs to some degree in about 2.5 out of 1,000 live births.
- Persons with spastic CP have stiff and jerky movements because their muscles are too tight.
- Persons with spastic CP often have a hard time moving from one position to another or letting go of something in their hand.
- Persons with CP look very unsteady and shaky.
- Persons with CP have very poor balance.
- Persons with CP have random, involuntary movements.
- Some persons with CP become very stiff, especially in the joints.
- Persons with CP may also have orthopedic problems that affect the spine, bones, joints, muscles, or other parts of the skeletal system.
- Persons with CP may experience seizures. The police must remember that this may involve a loss of consciousness, alternating rigidity and relaxation of muscles and a period of drowsiness or disorientation.
- Persons with CP may have intelligence within the entire range of possibilities.
- Persons with CP tend to experience difficulty with speech.
- Some persons with CP have a muscle imbalance in one of their eyes resulting in what is commonly called cross-eye or lazy eye.

SELF-CHECK

Directions: Check your basic background knowledge about **Cerebral Palsy** by responding to the following statements. Write "T" (for true) in front of each statement that is correct and "F" (for false) in front of each statement that is incorrect. Check your answers on page 23.

_____ 1. The primary identification factor is gait disturbance.

_____ 2. Persons with cerebral palsy represent approximately 5% of the population.

_____ 3. Persons with cerebral palsy never have over-lapping disabling conditions.

_____ 4. Persons with cerebral palsy have a greater inclination to commit crimes than non-disabled persons.

_____ 5. Persons with cerebral palsy are not unsteady and shaky.

_____ 6. Persons with cerebral palsy do not have seizures.

_____ 7. A characteristic of cerebral palsy may be a lazy eye.

_____ 8. Genetics is the single largest contributor to cerebral palsy.

_____ 9. Cerebral palsy as a condition is contagious.

_____ 10. Cerebral palsy as a condition remains relatively stable.

_____ 11. Cerebral palsy is a disorder of movement.

_____ 12. Persons with cerebral palsy may have problems with speech.

_____ 13. The walk of persons with cerebral palsy may resemble that of someone intoxicated.

_____ 14. Persons with cerebral palsy have difficulty releasing something in their grip.

_____ 15. All persons with cerebral palsy are mentally retarded.

LEARNING EXPERIENCES

Enabling Objective:	Role play with another participant focusing on the special characteristics of persons with **cerebral palsy**.
Learning Activities	**Special Instructions**
If possible, listen to remarks of one person with cerebral palsy that has experienced a confrontation with the police. Role play with another participant using the basic knowledge that you have just received. Read the *KEY POINTS*— listed on page 20. Demonstrate your basic knowledge by completing the self-check on page 21. Arrange with your instructor to complete this section of the learning guide by going through the performance test as per the standards on page 24 using the scene developed below.	

Role Playing Activity

Description of the scene:

As an on-duty officer, you are responding to a call from a convenience store that has reported making a sale to a man that was staggering and had slurred speech. The store attendant informs you that he suspected that the person was intoxicated and should not be out in public. The attendant has observed the direction in which the man left the premises and you pursue.

A couple of blocks away you observe the individual, and the store attendant's description of the man's walk appears very accurate. You approach, identify yourself and notice the slurred speech as well. What disabling condition might be present, and how do you gather additional information regarding his physical and/or mental state?

PERFORMANCE TEST

Participant's Name:	Date:

Competency:	Resolve an incident using basic knowledge of persons with **cerebral palsy**.	Test Attempt 1st 2nd 3rd

Directions:

Using information from the case study provided, complete the following activity per the performance standards listed on page 24.

Overall Evaluation	
Level Achieved	**Performance Levels**
	4. Can perform this skill without supervision and with initiative and adaptability to problem situations.
	3. Can perform this skill satisfactorily without assistance or supervision.
	2. Can perform this skill satisfactorily, but requires some assistance and/or supervision.
	1. Can perform parts of this satisfactorily, but requires considerable assistance and/or supervision.
Instructor will initial level achieved.	

ANSWERS TO SELF-CHECK

1. true	2. false	3. true	4. false	5. false
6. false	7. true	8. false	9. false	10. true
11. true	12. true	13. true	14. true	15. false

PERFORMANCE STANDARDS

Performance Standards For acceptable achievement, all items should receive a *yes* or *N/A* response	Yes	No	Not Appl.
When Approaching			
1. Greeted person with proper body language.			
2. Approached person with caution: a. observed for dress/physical appearance; b. observed adaptive behavior; c. observed for degree of life-threatening conditions.			
Interviewing/questioning person			
3. Used the following skills: a. spoke slowly b. used simple sentences c. asked appropriate questions d. re-used some questions at various intervals			
Family, neighbors and other witnesses			
4. Gathered additional information from: a. family members b. neighbors c. other witnesses			
Closure			
5. Resolved condition for which you were called to respond a. took subject into custody b. counseled with family members regarding alternatives c. referred to appropriate community resources			
6. Filed report a. completed written report by end of shift b. checked with family members within two day period of initial call			

Task/Competency: Resolve an incident involving a person with Epilepsy.

Introduction: Changing models in policing and in the care of persons with developmental disabilities (DD) are dual forces mandating that law enforcement officers be able to better understand members of this sub-population. A developmental disability refers to a disabling condition present since birth or the early developmental period.

Performance Objective: Given a subject with **epilepsy** involved in a problem situation, demonstrate your understanding of persons with epilepsy according to the information you have been given and by the standards on page 30.

Enabling Objectives:

1. Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with epilepsy.
2. Role play with another participant focusing on the special characteristics of persons with epilepsy.

Prerequisites: Completion of basic law enforcement training.

LEARNING EXPERIENCES

Enabling Objective: Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with **epilepsy**.

Learning Activities	Special Instructions
Listen to lecture on Epilepsy. Watch videos: 1. *Officer's Guide: Interacting with Disabled People* 2. *Making Contact: Communicating with Adults with Mental Retardation* 3. *Take Another Look - Police Response to Seizures and Epilepsy* Read the page entitled *KEY POINTS* that contains basic knowledge about epilepsy Demonstrate your knowledge of persons of this sub-population by completing the self-check on page 27 and check your answers (page 29).	

KEY POINTS

Developing Basic Background Information On Epilepsy

This section is to assist in developing a basic knowledge which will provide an additional tool when responding to a call involving a person with epilepsy.

- Remember that different categories of DD require differing techniques in initial contacts.
- Keep in mind that a range of possible situations exist with persons with epilepsy, and the majority of confrontations do not involve a crime.
- The role of the police officer in the majority of occasions involving persons with epilepsy will be that of a helper rather than an enforcer.
- People with epilepsy are generally intelligent, perceptive and articulate as any other member of the public, although occurrence of a seizure will mask these attributes until the person is fully recovered.
- People with epilepsy will experience a sudden change form normal to impaired.
- There are over 2.6 million Americans with epilepsy.
- Persons with epilepsy can be helped with medications which must be maintained when in jail.
- There are over twenty kinds of seizures associated with epilepsy.
- Seizures are a symptom of epilepsy.
- Epileptic seizures are the result of electrical discharges in one or more areas of the brain.
- Medication for epilepsy may cause side effects: trouble with balance and walking, itchy skin, noticeable smell in perspiration and breath and involuntary eye movements.
- There are two main categories of seizures: generalized and partial.
- Persons with epilepsy are no more likely to commit a crime than anyone else.
- The majority of persons with epilepsy are not dangerous to others.
- It is important for the police officer to remember that behavior is out of control for persons experiencing epileptic seizures.
- The most fundamental problem in identifying a person with epilepsy is the fact that too often the symptoms are mistaken for daydreaming or deliberate wrongdoing.
- Epilepsy can momentarily cause confused behavior and an inability to respond to police questioning.
- Seizures usually last only a couple of minutes; when police respond to a call the seizure is typically over, yet the person may appear confused, agitated or belligerent.
- Do not try to restrain someone during a seizure.
- Check for a medical identification bracelet.
- Seizures can occur anywhere.
- Seizures caused by alcoholism or illegal drug use may be more likely to occur during the evening hours, weekends and holidays because persons have exhausted their medication.

SELF-CHECK

Directions: Check your basic background knowledge about **Epilepsy** by responding to the following statements. Write "T" (for true) in front of each statement that is correct and "F" (for false) in front of each statement that is incorrect. Check your answers on page 29.

_____ 1. The role of the police officer when assisting with a seizure episode is that of a helper.

_____ 2. Persons with Epilepsy represent approximately 30% of the population.

_____ 3. Persons with Epilepsy never have over-lapping disabling conditions.

_____ 4. Persons with Epilepsy have a greater inclination to commit crimes than non-disabled persons.

_____ 5. Persons should be physically restrained during a seizure.

_____ 6. All persons with epilepsy are mentally retarded.

_____ 7. Epilepsy has multiple causes.

_____ 8. Genetics is the single largest contributor to Epilepsy.

_____ 9. Persons with epilepsy are generally dangerous.

_____ 10. A period of confusion may follow a seizure episode.

_____ 11. Seizures generally occur in public.

_____ 12. The peak period for seizures is during the lunch hour.

_____ 13. Seizure medication may case side effects.

_____ 14. There are four main categories of seizures.

_____ 15. Epileptic seizures are the result of electrical discharges in the heart.

LEARNING EXPERIENCES

Enabling Objective: Role play with another participant focusing on the special characteristics of persons with **epilepsy**.

Learning Activities	Special Instructions
If possible, listen to remarks of one person with epilepsy that has experienced a confrontation with the police. Role play with another participant using the basic knowledge that you have just received. Read the *KEY POINTS* listed on page 26. Demonstrate your basic knowledge by completing the self-check on page 27. Arrange with your instructor to complete this section of the learning guide by going through the performance test as per the standards on page 30 using the scene developed below.	

Role Playing Activity

Description of the scene:

As an officer, you have arrested a man on suspicion of burglary, and he is riding in the back of your police cruiser on the way to the police station. Suddenly, he lets out a hoarse cry, stiffens and begins to jerk his body rhythmically. You tell him to stop but he does not respond. You arrive at the station, and he is slumped over and uncooperative. What do you suspect is his disabling condition, and how should you respond?

PERFORMANCE TEST

Participant's Name:	Date:

Competency:	Resolve an incident using basic knowledge of persons with **epilepsy**.	Test Attempt 1st 2nd 3rd

Directions:

Using information from the case study provided, complete the following activity per the performance standards listed on page 30.

Overall Evaluation

Level Achieved	Performance Levels
	4. Can perform this skill without supervision and with initiative and adaptability to problem situations.
	3. Can perform this skill satisfactorily without assistance or supervision.
	2. Can perform this skill satisfactorily but requires some assistance and/or supervision.
	1. Can perform parts of this satisfactorily, but requires considerable assistance and/or supervision.
Instructor will initial level achieved.	

ANSWERS TO SELF-CHECK

1. true	2. false	3. true	4. false	5. false
6. false	7. true	8. false	9. false	10. true
11. false	12. false	13. true	14. false	15. false

PERFORMANCE STANDARDS

Performance Standards For acceptable achievement, all items should receive a *yes* or *N/A* response	Yes	No	Not Appl.
When Approaching			
1. Greeted person with proper body language.			
2. Approached person with caution:			
a. observed for dress/physical appearance;			
b. observed adaptive behavior;			
c. observed for degree of life-threatening conditions.			
Interviewing/questioning person			
3. Used the following skills:			
a. spoke slowly			
b. used simple sentences			
c. asked appropriate questions			
d. re-used some questions at various intervals			
Family, neighbors and other witnesses			
4. Gathered additional information from:			
a. family members			
b. neighbors			
c. other witnesses			
Closure			
5. Resolved condition for which you were called to respond			
a. took subject into custody			
b. counseled with family members regarding alternatives			
c. referred to appropriate community resources			
6. Filed report			
a. completed written report by end of shift			
b. checked with family members within two day period of initial call			

Task/Competency: **Resolve an incident involving a person with Hearing Impairments.**

Introduction: Changing models in policing and in the care of persons with developmental disabilities (DD) are dual forces mandating that law enforcement officers be able to better understand members of this sub-population. A developmental disability refers to a disabling condition present since birth or the early developmental period.

Performance Objective: Given a subject with **hearing impairments** involved in a problem situation, demonstrate your understanding of persons with hearing impairments according to the information you have been given and by the standards on page 36.

Enabling Objectives:

1. Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with hearing impairments.
2. Role play with another participant focusing on the special characteristics of persons with hearing impairments.

Prerequisites: Completion of basic law enforcement training.

LEARNING EXPERIENCES

Enabling Objective: Demonstrate your knowledge of the unique factors accompanying the identification of and communicating with a person with a **hearing impairment**.

Learning Activities	Special Instructions
Listen to lecture on Hearing Impairments. Watch videos: 1. *Officer's Guide: Interacting with Disabled People* 2. *Making Contact: Communicating with Adults with Mental Retardation* 3. *Take Another Look - Police Response to Seizures and Epilepsy* Read the page entitled *KEY POINTS* that contains basic knowledge about hearing impairments. Demonstrate your knowledge of persons of this sub-population by completing the self-check on page 33; compare with answers on page 35	

KEY POINTS

Developing Basic Background Information On Hearing Impairments

This section is to assist in developing a basic knowledge which will provide an additional tool when responding to a call involving a person with hearing impairments.

- Remember that different categories of DD require differing techniques in initial contacts.
- Keep in mind that a range of possible situations exist with persons with hearing impairments and that the majority of confrontations do not involve a crime.
- Persons with hearing impairments are no more likely to commit a crime than anyone else.
- There are over 40 million persons in the United States with significant hearing impairment; approximately two-thirds of that number represent hearing loss associated with advanced age.
- Persons are considered hard of hearing when capable of only partial recognition of the spoken language or if conversation must be close and unusually clear to be understood.
- They are more like you, that unlike you.
- The real handicap of deafness is being cut off from normal means of acquiring and transmitting language.
- Persons with hearing impairments try to cope with auxiliary means of communication such as sign language, lip reading, reading and writing.
- Lip reading is the least reliable method of communication.
- Sign language is the preferred method of communication.
- Every hearing impaired person copes with his or her communication loss in a different way.
- Persons who have lost their hearing due to advanced age usually do not know how to use sign language.
- Persons with hearing impairments can be mistaken for persons who are senile, mentally ill or mentally retarded.
- It is a state law in Texas that deaf persons be provided with a qualified interpreter involving any governmental procedure (Code of Civil Procedure 1965, (d), Art. 38.1). Under state law, these services are paid for by the governmental body involved in the case.
- Remember, you, not the interpreter, are the one talking to the person with a hearing impairment.

SELF-CHECK

Directions: Check your basic background knowledge about **hearing impairments** by responding to the following statements. Write "T" (for true) in front of each statement that is correct and "F" (for false) in front of each statement that is incorrect. Check your answers on page 35.

_____ 1. Advanced age is the largest category of persons with hearing impairments.

_____ 2. Communication loss is the major hardship imposed by hearing loss.

_____ 3. All persons with hearing loss are able to lipread.

_____ 4. Writing is the preferred method of communicating with a person that is deaf.

_____ 5. Deafness is total hearing loss.

_____ 6. The majority of the elderly with hearing loss know sign language.

_____ 7. Persons who are hearing impaired are also retarded.

_____ 8. There are about 40 million persons in the U.S. with hearing impairments.

_____ 9. Texas law mandates the use of an interpreter involving any governmental procedure.

_____ 10. Persons with hearing impairments do not know how to read and write.

_____ 11. Deafness and hard of hearing are the same

_____ 12. There is no one communication method used by all persons with hearing impairments.

_____ 13. Persons with hearing impairments are deaf.

_____ 14. Lipreading is the most reliable method used by persons with hearing impairments.

_____ 15. You, as the police officer, not the interpreter, are the one talking to the person with a hearing impairment.

LEARNING EXPERIENCES

Enabling Objective: Role play with another participant focusing on the special characteristics of persons with **hearing impairments**.

Learning Activities	Special Instructions
If possible, listen to remarks of one person with hearing impairments that has experienced a confrontation with the police. Role play with another participant using the basic knowledge that you have just received. Read the *KEY POINTS* listed on page 32. Demonstrate your basic knowledge by completing the self-check on page 33. Arrange with your instructor to complete this section of the learning guide by going through the performance test as per the standards on page 36 using the scene developed below.	

Role Playing Activity

Description of the scene:

As an officer, you respond to a call involving a two-car accident. The drivers were the only passengers in either car and neither was seriously injured. As you arrive, the drivers are accusing each other of being at fault. You inquire if there were witnesses to the accident. It appears that a pedestrian did see the accident and each give a similar description of the person who walked away.

You complete your work at the accident scene and proceed in the direction in which the witness left the scene. You make a routine stop at a popular donut shop and notice a young man that fits the description of the alleged witness of the car accident. You introduce yourself to the person and he appears to be reading your lips and not being very responsive to your questioning. What clue do you have to his disabling condition? Try to communicate with the person; solicit basic information regarding the car accident.

PERFORMANCE TEST

Participant's Name:	**Date:**

Competency:	Resolve an incident using basic knowledge of persons with **hearing impairments.**	Test Attempt 1st 2nd 3rd

Directions:

Using information from the case study provided, complete the following activity per the performance standards listed on page 36.

Overall Evaluation

Level Achieved	**Performance Levels**
	4. Can perform this skill without supervision and with initiative and adaptability to problem situations.
	3. Can perform this skill satisfactorily without assistance or supervision.
	2. Can perform this skill satisfactorily, but requires some assistance and/or supervision.
	1. Can perform parts of this satisfactorily, but requires considerable assistance and/or supervision.
Instructor will initial level achieved.	

ANSWERS TO SELF-CHECK

1. true	2. true	3. false	4. false	5. true
6. false	7. false	8. true	9. true	10. false
11. false	12. true	13. false	14. false	15. true

PERFORMANCE STANDARDS

Performance Standards For acceptable achievement, all items should receive a *yes* or *N/A* response	Yes	No	Not Appl.
When Approaching			
1. Greeted person with proper body language.			
2. Approached person with caution:			
a. observed for dress/physical appearance;			
b. observed adaptive behavior;			
c. observed for degree of life-threatening conditions.			
Interviewing/questioning person			
3. Used the following skills:			
a. spoke slowly			
b. used simple sentences			
c. asked appropriate questions			
d. re-used some questions at various intervals			
Family, neighbors and other witnesses			
4. Gathered additional information from:			
a. family members			
b. neighbors			
c. other witnesses			
Closure			
5. Resolved condition for which you were called to respond			
a. took subject into custody			
b. counseled with family members regarding alternatives			
c. referred to appropriate community resources			
6. Filed report			
a. completed written report by end of shift			
b. checked with family members within two day period of initial call			

SENSITIZING POLICE OFFICERS TO PERSONS WITH DEVELOPMENTAL DISABILITIES

ADVANCED OFFICER TRAINING

Topics Covered During this 8 Hour Session

- Basics of Developmental Disabilities
- Mental Retardation
- Autism
- Cerebral Palsy
- Epilepsy
- Hearing Impairments

INCIDENT INVOLVING POLICE OFFICERS AND A TEENAGER WITH A DEVELOPMENTAL DISABILITY

The following incident occurred at the Parks Mall located in Arlington, Texas, on a Saturday in May, 1997. A 15 year-old girl was shopping with friends when she experienced a complex-partial seizure. One of her friends immediately began to seek security personnel at the mall. Meanwhile, the teenager wandered away from her friends, going out of the mall into the parking lot. She was seen wandering the parking lot by a Parks mounted patrol officer. When he called the Parks security for assistance, Arlington police officers responded.

The first thing that responding officers did upon locating the young lady who was approximately 4'10" tall and weighing 80 pounds was to place her in handcuffs. During the brief period of the seizure, she was unable to communicate in any fashion. As soon as the seizure ended, she was able to explain her condition to the officers. They explained to her that they had used handcuffs because her behavior resembled that of actions that are drug-induced. The officers further explained their use of restraints saying that they wanted to remove her to a more secluded location but that she firmly resisted. In addition, the officers said that she was attempting to scratch her face and that of the officers. Considerable time passed before the handcuffs were removed as police officers were slow to be satisfied that both she and her friends were being truthful about her condition.

Outcome: The only physical injury experienced by the teenager from this incident was the whelps and bruised places left on her wrists by the handcuffs. There is a great deal of emotional stress and social stigma that accompanies having epilepsy as well as knowing where the incident occurred and that she was handcuffed and questioned in front of her friends at the shopping mall.

Remedy: Sensitivity training for all police department personnel regarding the major categories of developmental disabilities as many persons experience overlapping conditions. Seizures are common to a high percentage of all persons with life-long disabilities which compels officers to have a basic understanding of the unique characteristics of these conditions and their accompanying behavioral manifestations as well as insight into proper responses during an incident regardless of the presence or absence of criminal intent.

Information available on assisting individuals experiencing complex-partial seizures stresses that they should not be restrained during the episode. Literature published by the Epilepsy Foundation of America states that efforts to restrain may produce an unconscious aggressive response.

Person who regularly experience seizures should take precautionary measures involving some form of external identification such as a piece of medic alert jewelry and/or an informational card appropriately placed in her purse.

Developmental Disabilities

Objectives

Performance Objective:

Given a subject with a developmental disability involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 6 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

Enabling Objectives:

1. Demonstrate general knowledge of the unique factors of persons with any of the major categories of D.D.
2. Role play with another participant with a D.D. in a simulated situation with emphasis on identification by category.

Identification of a Person with D.D.

The Identification of a person with a developmental disability is not always easy. The majority of basic skills required hinge around discerning the classification of the disability (i.e., mental retardation, autism, cerebral palsy, epilepsy, hearing impaired) and the degree of the condition. The majority of efforts in identification will be explained as the material progresses through the specific disabling conditions. Extra emphasis will placed on mental retardation as it is the largest category.

The following are some items for the officer to keep in mind when attempting to identify a person with a developmental disability:

- Identification of a person with D.D. is most difficult when encountering someone who is mildly retarded.
- Persons with mild retardation are streetwise and are very clever at masking their limitations.
- Be familiar with the names of state schools, community based programs, special education programs, group homes, and respite programs in your area.
- Know local jargon relevant to group homes.
- The person may not want their disability to be noticed.
- The person may be overwhelmed by police presence.
- The person may be very upset at being detained and/or try to run away.

The officer should also observe for physical appearance:

- Is the person appropriately dressed for the season?
- Does the individual show any physical defect, that is, unusual physical structures?
- Does the individual appear uncomfortable with his/her body, or is there awkwardness of movement, poor motor coordination in walking, writing or other physical movements?

- Does the individual have a slow reaction to such stimuli as questioning?
- Inquire about education level.
- Ask if the person was in special education classes or vocational education.
- Obtain information from the person while conversing about his or her family and childhood history.
- Are there obvious speech problems?
- Is the person attentive?
- Does the person exhibit an inability to use abstract reasoning?
- Observe for social behavior
- Is the person easily frustrated?
- Does the person avoid questions concerning a disability?

Background Information

Impairment:

A loss of physical or mental functioning at the organ level.

Disability:

When the effect of the impairment is severe enough to inhibit functioning.

Handicap:

Obstructions imposed by society that inhibit the pursuit of independence.

There are no handicapped persons, only handicapping conditions imposed by society. Stair steps are handicaps for persons in a wheelchair. An impairment is at the organ level. In most cases, during the course of this study we are talking about the central nervous system. When the impairment is severe enough that it impacts the person, we have a disability. When a person's disability is severe enough, the person with the disability impacts the family. Every family that has raised a child with a developmental disability is permanently changed. Society is impacted when services are needed.

Basic D.D. Definition

A developmental disability is a severe chronic disability which is attributable to a mental or physical impairment or a combination of these factors. The onset occurs before the age of 22, and results in substantial functional limitations in three or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency. In addition, a developmental disability reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and, except that such term, when applied to infants and young children means individuals from birth to age five, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

A good way to understand a D.D. is to think of it as:

- a condition that an individual may have had since birth or childhood,
- which during adulthood has prevented him or her from being fully independent, socially or vocationally,
- and which continues on into old age.

Why is this Training Important for Police Officers

Persons with life-long disabilities have experienced increased visibility in the community only in recent years. Multiple forces have converged to place emphasis on the needs of this subpopulation from the perspective of persons employed in the field of law enforcement. The **first** major underlying reason for police to be informed about D.D. is that for the first time in our nation's history, we have escalating and very significant numbers of persons with D.D. who are entering the public school systems. A **second** factor has evolved as the result of social research. In previous decades, large numbers of persons with developmental disabilities were institution-alized in state schools and/or large intermediate care facilities for the mentally retarded. The results of continued research have indicated that the grouping of persons with like disabilities contributes nothing to either the quality or quantity of their social exchanges.

The **third** factor contributing to this emerging social problem is the result of the community inclusion model which has contributed to a growing number of persons with D.D. involved with law enforcement agencies and/or the criminal justice system.

Categories of Developmental Disabilities

- mental retardation
- autism
- cerebral palsy
- epilepsy
- deafness
- blindness
- orthopedic impairments
- learning disabilities
- other neurological/sensory impairments

Prevalence Rates of D.D.

The prevalence rate of persons in the general population varies by source, by country and by type of measurement. It is generally thought that, when cumulatively considering all types of D.D., approximately 5 percent of the general population is involved. Authorities (too numerous to reference) seem to be in agreement that

approximately three percent of the population have some degree of mental retardation. Further, most sources report that approximately 90 percent of those with mental retardation as their primary disabling condition test in the range of **mild** retardation. It is generally believed that in excess of 80 percent of the entire number with mental retardation have environmental conditions, such as the living environment, as the primary contributor.

Offenders with D.D.

The number of persons with D.D. who commit crimes cannot be ascertained with much confidence. Obviously, it is impossible to know if a crime was committed by a person with D.D. unless the perpetrator is apprehended, tried and convicted. Frequently the apprehended person is not identified as having a life-long disability by the police, the jails, the courts or by his/her attorney. It is not until the defendant is convicted and sentenced to prison that testing to identify the existence of D.D. is conducted.

Some authorities believe that the rates of mental retardation as a category are often overstated due to persons likely being frightened, hostile, non-cooperative, having emotional illnesses or symptoms of other conditions at the time they are being tested. Testing is usually done immediately after entering prison and the person has not stabilized or adapted to the new environment.

The following characteristics are known about federal and state prisoners with D.D.

- The majority are male.
- The majority are from minority groups. In Texas 8 out of 10 are either Black or Hispanic. This is probably due to economic considerations.
- Many defendants come from broken or dysfunctional families and have little community support.
- Often they develop low self-esteem from performing poorly in school, along with a low level of expectation from family members.
- The majority have mild mental retardation.
- Some carry a dual diagnosis of D.D. along with mental illness
- Some inmates have additional disabling conditions.
- The majority of crimes committed are petty offenses and public disturbances.

Suggested Activity Using the Trainee's Guide:

- Check your own general knowledge about **developmental disabilities** on page 2 and 3, answer the questions on page 3. Compare your answers with the answers on the following page.

Key Points About Developmental Disabilities

- Different categories of D.D. require differing techniques in initial contacts.
- A wide-range of possible situations exist with persons with D.D. and that the majority of confrontations do not involve a crime.
- There is a wide discrepancy between chronological age and intellectual development.
- A developmental disability is generally present from birth.
- There is a wide range of severity of each disabling condition.
- The word developmental, in this context generally, infers a limitation the person has in exercising full control over his/her life.
- A developmental disability may or may not imply mental retardation.
- A developmental disability may be accompanied with reduced adaptive skills.
- People have *disabilities*, not *handicaps*.
- Persons with D.D. are no more likely to commit a crime than anyone else.
- Persons with D.D. are frequently manipulated by their non-disabled peers.
- Persons with life-long disabilities may be overwhelmed by the presence of police officers.
- Physical appearance tells little, yet appropriate dress offers a better clue to a person's social skill.
- Speech fluency along with the time involved in responding to questions can provide valuable information.
- Persons with D.D. frequently do not want their disability noticed and avoid questions concerning their limitations.
- Be sensitive to the dignity of the person.
- Do not assume that someone with a developmental disability is totally incapable of understanding or communicating.
- Treat adults as adults, don't treat adults with D.D. as children.
- Give the same amount of respect to a person with a developmental disability that you would give to any other person.
- Remember that a person with D.D. is more like you than unlike you.

INCIDENT INVOLVING POLICE OFFICERS AND A YOUNG ADULT WITH MENTAL RETARDATION

The police were called to Beaver Park. A young man had been observed standing for some time near the playground watching some children play in a circle. According to reports he walked over to the children, joined the circle, and began to wrestle with a little girl. The man was arrested and charged with an incident act with a minor." At the time of his arrest, the man had no identification on him, appeared very frightened and confused, and tried once to run from the arresting officer. In the police car he seemed to have difficulty understanding what was being said to him. His attention wandered off repeatedly. At the police station, the man was visibly shaken after being brought out of holding.

He was questioned in reference to the incident at the park, responding with only a "yes" to each question. "Were you at the park this morning for any special reason?" He responded with a "yes." "Were you watching the children play?" He responded with a "yes." "While you were watching them play, did you intend to sexually molest the victim?" Again he responded with a "yes." A statement was typed and the frightened man scribbled his name at the bottom of the page.

Carl is mentally retarded with an IQ of 60. He had a very difficult time understanding what had happened to him. The attorney appointed to his case had little understanding of the nature of retardation. He realized that Carl was slow, but did not request a pretrial examination. Witnesses testified that Carl had been seen at the playground on several previous occasions. No one raised the question about his competency or criminal responsibility. No one raised the possibility that Carl may have been rejected by persons his own age and as a result tried to associate with children who were closer to his mental age. In addition, no one asked Carl if he knew what sexual molesting meant.

Outcome: Carl pleaded guilty and spent six years in a maximum security facility. In prison, Carl was placed in various educational programs where he did poorly. His fear of being laughed at and of showing his limitations resulted in his repeated absences from these programs. He soon dropped attendance completely and was assigned to a variety of cleaning jobs. Because he wanted friends, he was all too willing to follow any suggestions given which invariably caused him trouble. Prison guards recorded every rule infraction resulting in his spending time in solitary of several occasions. At the time of his parole, Carl sat mute as the prison board characterized him as a loner. Coming out of prison, he managed a meager existence on the streets. Two months after his release from prison, Carl was rearrested, after being observed watching and attempting to join a group of children at the playground.

Remedy: Sensitivity training for all department personnel regarding mental retardation. In addition, communication provides a vital link for whether persons with mental retardation come into contact with the police as victims, offenders, or witnesses, there obviously needs to be some communicative adjustments made. The consequence of not doing so is that victims remain isolated, offenders are either not brought to account or fail to access their rights, and witnesses remain unheard.

Mental Retardation

Objectives

Performance Objective:

Given a subject with mental retardation involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 12 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

Enabling Objectives:

1. Demonstrate general knowledge of the unique factors of persons with mental retardation.
2. Role play with another participant with mental retardation in a simulated situation with emphasis on identification and communication.

Identification of a Person with Mental Retardation

Identification of a person with M-R is not always easy particularly when encountering someone who is mildly retarded. This is because the majority are in the *mild* range, therefore a higher degree of interaction between the police officer and the person is required in comparison to trying to determine mental illness. In the majority of cases persons with M-R cannot be identified by physical characteristics.

The identification is often delayed until after the trial and sentencing. This delay may prevent the prosecution, the defense and the judge and jury from appropriately considering the effects of mental retardation such as determining competence and criminal responsibility. Also, persons with mild retardation are streetwise and are very clever at masking their limitations. The following are some general areas to consider in the identification process:

Physical appearance - appropriately dressed for the season, unusual physical structures, awkwardness of movement, slow reaction to questioning;

Educational History - check records, ask for cards issued by city transportation agencies, obtain information from the person, i.e., proper school grade for age, or in special education class;

Speech/Language Problems - obvious speech defects, understanding of questions, provides appropriate answers, signs of deafness, parroting of responses, comprehend his/her Miranda rights, attentive, use of abstract reasoning, limited vocabulary, can describe facts of an offense;

Social Behaviors - associate with younger persons, desire to please, rejects personal space of others, aware of surroundings, behavior appropriate for his/her age, response to crisis, mirror the action of others, easily influenced by others, presence of an advocate, easily frustrated, avoids questions;

Performance Tasks - try to keep the tasks within the context of the situation. Ask the person to: Identify self by name, read and write, use the telephone, identify their number in the telephone book, describe someone's appearance, give and/or understands directions, tell time on a regular watch or clock, define some words, aware of time and place.

Identification Summary

In general, persons with M-R will provide inferior responses and those responses will be a function of his/her level of retardation. While interviewing the person, the officer should be aware of the person's reactions to the questions. Nonverbal behavior or body language often providers as much information as the answer itself. Avoiding questions regarding his/her background, such as special schooling or vocational training, large gaps in answers or even silence may all be an indication of retardation. Rephrasing the question once or twice might help get an answer. Obvious reluctance to discuss what might appear to be a simple matter, such as education, is a valuable clue in itself and should not require a constant attempt to help gain a satisfactory answer.

Mental Retardation Defined

Mental retardation is characterized by significantly subaverage intellectual functioning (I.Q. score below 70) existing concurrently with related limitations in two or more adaptive skill areas. Mental retardation is further characterized as a fundamental difficulty in learning and performing certain daily life skills that involve the realms of conceptual, practical and social intelligence. A less complex and less wordy definition of this the largest category of developmental disabilities is:

- **Significant below average intellectual functioning**;
- **Deficits in adaptive behavioral functioning,** which must exist concurrently with below average intellectual functioning and generally occur within the context of community environments typical of the person's age peers. A significant disability in two or more adaptive skill areas has to exist. The 10 areas of skills are as follows: Communication, Self-Care, Home Living, Social Skills Community Use Self-Direction Health and Safety Functional Academics, Leisure, and Work;
- **Manifests before age 18** which is a deviation from the criteria as set forth in the basic definition of a developmental disability. This age is used as it approximates the age when persons in American society typically assume adult roles as the result of completing basic public secondary education.

Prevalence Rate of M-R

Three (3) percent of the general population has an intelligence score that falls some degree below average . One of the important facts to keep in mind is that the rate of persons that are incarcerated is far out of proportion to their numbers in the general population. Reports vary from 10 percent to 75 percent with many professionals believing that as much as 30 percent of the prison population is M-R.

Of the retarded, at least 85 to 90 percent are in the educable *mild* range with I.Q. scores in the range of 50-69 (about 2.5% of the general population). Of the remaining, about four-tenths of one percent (.4%) is in the range between 30-49 and labeled *moderate*. One tenth of one percent (.1%) is considered *severe* or below an IQ of 30.

Police Situations

Police officers come in contact with persons with mental retardation in four different types of situations:

- **Victim of a crime** - Persons with M-R are easily taken advantage of which lends itself to being open to suggestions. He/She may be lured into a non-observable area and then robbed or beaten simply because they could not recognize the danger of the situation. Frequently these persons are subject to verbal, physical or sexual abuse. In addition, these persons frequently will not know when he/she has been victimized. It may be necessary for an officer to explain to a victim with M-R what has happened in order to secure relevant information for a case.
- **Witness** - Persons with M-R can serve as effective witnesses, however, extra patience may be required. The officer should remember that a person with M-R may have a shorter attention span and have problems with abstract thinking.
- **Offender** - The majority of offenses committed by these persons are misdemeanors, less serious felonies and public disturbances. Studies show that not only are persons with M-R more likely to be arrested, but also to be convicted and sentenced more than other offenders. Estimates of those found guilty and sentenced run as high as 30 percent. Likewise, persons with M-R may very innocently be involved in a crime thinking that they are doing someone a favor such as transporting illegal substances.
- **General police contacts** - In all situations, it is extremely important for the officer to proceed in the following manner when encountering a person with M-R.
    - Make the person feel safe and comfortable in the environment.
    - Assure the person that you are a friend, and try to calm him/her if agitated.
    - Use a normal tone of voice.
    - Use patience and proceed slowly to be sure the person understands your questions and his/her rights.

Officer's Attitude

- Use an average attitude.
- Use a non-threatening attitude.
- Be patient.
- Take time giving or asking for information.
- Use firm and calm persistence if the person fails to comply or acts aggressive.

The officer's success requires that they recognize that their contribution to the conversation is the key determinate. Persons with M-R will respond better if the officer remembers that their mental age is less than their chronological age, therefore

persons with M-R have a much reduced capacity to understand anything abstract. The officer should break information needs into small chunks and use simpler language.

Communicating with Persons with M-R

- Leveling - the officer and the person should be at the same eye level.
- Eliminate as many distractions as possible.
- Remove others that might be a distraction.
- Use open-ended simple statements and do not supply answers.
- Provide feedback and be sincere.

Restriction and control of meaning can occur if you do not recognize when a person has not understood what you are saying. This can also occur by failing to recognize that a person, especially with M-R might need an individual style of help or support in order to supply the information you need. In this context, the officer is cautioned to remember:

- Persons with M-R are first and foremost people.
- Persons with M-R are more like the officer than unlike them.
- They cannot be required to forego any rights or human considerations afforded to everyone else.
- Treat adults as adults, do not treat adults who have mental retardation as children. Give the same amount of respect to a person with M-R that you would give to any other person.
- They are subject to the same influences as the non-retarded.
- They are sensitive to other's speech and actions and will respond in the manner in which they are treated.
- They represent a wide range of descriptors and abilities.
- They should be approached in a positive manner, not be belittled.
- Do not assume that someone with a developmental disability is totally incapable of understanding or communicating.
- Persons with M-R do not like being called retarded or even have the word retardation used in reference to their disability. Use the phrase person with a disability.
- The person may not want their disability to be noticed.
- The person may be overwhelmed by police presence.
- The person may be very upset at being detained and/or try to run away.
- May have difficulty describing facts or details of offense.
- May have a reluctance to discuss the matter.
- Be aware of a retarded person's attempts to please others.
- The person usually understands more than he/she can indicate.

Communication Tips

- When possible, arrange for a quiet and private setting.
  - This will help the person relax, enable the officer to interview the person, and reduce any embarrassment the person might feel in a more public setting.
  - Try to calm the person, make the person feel safe and comfortable in the environment, and assure the person that you are a friend.
  - Avoid any rapid-fire questions - this serves to intimidate or unnerve the person
- Speak directly to the person
  - Speak slowly and clearly.
  - Use simple language and vocabulary.
  - Keep sentences short.
  - Break complicated series of instructions or information into smaller parts.
  - If possible use visual aids, picture symbols, diagrams and actions to help convey meaning.
  - Use concrete terms. Abstract ideas may confuse the person with disability.

Additional Communication Tips

- Repeat and rephrase questions once or twice.
- Do not badger the person, it might result in uncooperative behavior.
- Ask for concrete descriptions: colors, clothing, etc.
- Avoid confusing questions about reasons for behavior.
- Do not ask leading questions.
- Ask open-ended questions.
- Avoid yes and no questions.
- Be aware of the person's reactions to the questions.
- Listen carefully to the content of the answer.

Everyone has the right to be heard and responded to in a language they understand. It is a challenge of the entire criminal justice system to make that right a reality for people with M-R.

Suggested Activity using the Learner's Guide:

- Check your own general knowledge about **mental retardation** on page 8, and answer the self-check questions on page 9. Compare your answers with the answers on page 11.

KEY POINTS

- Different categories of D.D. require differing techniques in initial contacts.
- A range of possible situations exist with persons with mental retardation, and the majority of confrontations do not involve a crime. The typical encounter will require the police to be a helper rather than an apprehender.
- There is a wide discrepancy between chronological age and intellectual development.
- Persons with M-R are no more likely to commit a crime than anyone else.
- Persons with mental retardation comprise about 3% of the general population.
- The majority of persons with mental retardation are in the mild category.
- Mental retardation is usually accompanied with reduced adaptive skills.
- Persons with mental retardation have poor recall of time of day and sequence of events.
- Genetics is only a minor contributor to mental retardation.
- Persons with mental retardation tend not to be violent.
- Persons with mental retardation are subject to being exploited by others.
- Most delinquent acts committed by persons with M-R are the result of inferior social skills.
- A basic principle used in interviewing a person with M-R is to exercise patience.
- Educational history provides insights into the identification process.
- Vocabulary level and grammar usage are good identification clues.
- Observe the age level of the friends of the person with M-R.
- Basic performance tasks provide excellent information such as ability to give directions to their home, or awareness of date, time, month, year and city where they live.
- Remember that their mental age is less than their chronological age.
- Remember that persons with M-R might not understand their Miranda rights.
- Be aware that a person with M-R may attempt to please others. Therefore, in a criminal justice situation, the person with M-R might take responsibility for a crime that they have not committed.
- Persons with developmental disabilities do not like being called "retarded" or even have the word "retardation" used in reference to their disability. Use the phrase "person with a disability."
- Remember that a person with a disability is more like you than unlike you.
- A person with M-R is sensitive to your actions and speech.
- Do not assume that a person with M-R is totally incapable of understanding or communicating.

INCIDENT INVOLVING POLICE OFFICERS AND A YOUNG ADULT WITH AUTISM

The following event occurred in December of 1993, in the borough of Penbrook, a suburb of Harrisburg, Pennsylvania. A detective employed by the city of Harrisburg, was driving down a street of Penbrook when he observed a young black male walking around a house peering in the windows. The detective, thought the subject was attempting to break into the house. He radioed his communication center reporting a possible burglary in progress and requested a patrol officer to respond. The detective waited until the Penbrook officer arrived and then both entered the property and confronted the suspect.

The officers identified themselves to the 19 year old who responded with "**no, no**," and turned his back to them. The officers believed the subject's actions to be suspicious and proceeded to subdue the subject. They handcuffed him on the ground. The mother then ran from the inside of the house to the area where she heard the screams from her son. She identified her son to the officers, stating that he lived at that residence. She then answered questions about her son. It was learned that her son suffered a separated shoulder from the arrest tactics used by the two officers. In the discussion with the subject's mother, the Penbrook officer stated that his earlier contacts at this residence had been with a white family.

Other information known to the officers at the time of this incident include the fact that the various police departments of the Harrisburg area had experienced numerous complaints about a "peeping tom," and that four women had been shot, possibly by the peeping tom. Thus they assumed that this might be the suspect of the alleged complaints. On the other hand, the mother told officers that they had lived in the house for six months and that during the first month the police were called by a neighbor because the autistic son was looking in the windows of their unattended vehicle. The mother told the responding officers then about her son's disabling condition. The officers told her that they would notify other members of the police department.

Outcome: The Penbrook police department was put in crisis. Besides officers being embarrassed by the incident, which was within their realm of training, public trust was diminished. Both officers and both cities were then named in civil litigation.

Remedy: Sensitivity training for police officers in recognizing and handling citizens with **autism** is a necessity. In addition, the information given by the mother on the initial police contact should have been disseminated by whatever method that department had in place at the time. Therefore, the detective on his observance of the subject at that address could have been advised before the contact.

Autism

Objectives

Performance Objective:

Given a subject with autism involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 18 in the Trainee's Guide. Include such factors as general information, identification by type of condition, communication and community resources.

Enabling Objectives:

1. Demonstrate general knowledge of the unique factors of persons with autism.
2. Role play with another participant with autism in a simulated situation with emphasis on identification and communication.

Identification of Persons with Autism

General things for police officers to keep in mind as persons with autism exhibit some or all of these symptoms:

- may have sensory impairments
- may have uneven patterns of intellectual functioning
- May engage in repetitive behavior
- like a fixed routine
- may have marked restriction of activity and interests
- do not like to be touched

In criminal justice situations the person with autism:

- may not understand his/her rights
- may have difficulty remembering facts or details of offenses
- may become anxious in new situations
- may not understand consequences of their actions

Autism is a developmental disorder characterized by three closely related conditions: impaired social relating and reciprocity, abnormal language and communication development and a restricted behavioral repertoire that may include repetitive activities and routines.

- **Impaired Social Behavior** - lack of awareness of social rules and lack of awareness of or attention to others, a stand-offish manner, lack of eye contact inappropriate emotional responses, ritualistic behaviors, no fear of real dangers, distress for no discernable reason, difficulty mixing with others, inappropriate attachments to objects, deliberate soiling.
- **Impaired Language Skills** - limited verbal abilities, may appear deaf, may repeat words or phrases, difficulty expressing needs, inability to understand what others are saying, lack of speech or impaired speech patterns, impaired

pitch, stress, rate, volume or rhythm of speech, difficulty with abstract concepts, pronoun reversals, parroting of responses, poor quality and quantity of receptive/expressive language.

- **Restricted Behavioral Repertoire** - may have a preoccupation with: matching objects, blinking compulsively, switching lights on and off, dropping things repetitively, jumping, rocking, hand-shaking, flicking objects, chin-tapping, head-banging, clapping, tearing paper, breaking glass, spinning things/spinning oneself or running in circles, fascination for colored and shiny objects.

Major Aspects

Persons with autism are subject to behavioral changes, and these typically represent the occasions when police are involved due to a non-understanding by others. Persons with autism have experienced countless injustices by the criminal justice system, of which many of these incidences have raised the level of awareness on the part of society for the need for police training on all the categories of D.D..

The vast majority of research on persons with this condition has been conducted on/with children. Until recently, children with autism never grew up to be called adults with autism. Instead, they were called schizophrenic or mentally retarded, and were usually institutionalized. Why were adults with autism not called *autistic*? Until recently, there were not residential, training or employment opportunities for adults with autism, so the only way they could receive services was to be labeled something else. Once labeled, the easiest thing to do was to shut them away in institutions.

There are no medical tests or biological markers to aide in the determination of the disorder, thus the sole determination is behavioral based. As there are no physiological tests at this time to determine whether a person has autism, the diagnosis of autism is given when an individual displays a number of characteristic behaviors. Because of its low prevalence, few professionals receive little exposure to persons with autism in the course of their training and are unfamiliar with its behavioral expression.

The second problem arises due to the fact that characteristics and behavioral manifestations often vary as a function of age or developmental level. Diagnostic features prominent during the preschool years may not be the same as those seen in middle childhood. A third factor is that of overlapping conditions between autism and other forms of D.D.. Lastly, the body of knowledge about autism continues to expand and therefore many facts become outdated.

There is no adjective which can be used to describe every type of person with autism because there are many forms of this disorder. For example, some individuals are anti-social, some are asocial and others are social. Some are aggressive toward themselves and/or aggressive toward others. Approximately half have little or no language, some repeat (or echo) words and/or phrases and others may have normal language skills.

Prevalence of Autism

Autism is a rare disorder, yet its prevalence rate makes it the third most common developmental disorder. The most cited statistic is that autism occurs in 4.5 out of 10,000 live births. Autism is four times more likely to affect males than females. Gender ratios seem to differ as a function of intellectual ratio, with a higher percentage of females found at lower intellectual levels. This gender difference is not unique to autism since many developmental disabilities have a greater male to female ratio. Autism appears to be distributed equally among all social classes.

Intelligence and Autism

The entire range of intelligence is possible for persons with autism, frequently persons with autism may show an unevenness of development precipitating a display of talent in certain limited areas such as music or mathematics, while being deficient in areas related to living skills, including their ability to communicate and relate to others. Most persons with the condition need structure, supervision and guidance in much of what they do.

Approximately 70 percent of all persons with autism function within the mentally retarded range. Persons of any age with autism do not test up to their abilities because these results are probably affected by the communications difficulties associated with the condition. Many develop seizures during adolescence and this tends to be those of IQ scores less than 70. It is rare to find seizures in persons with autism and a normal IQ. About 10% of autistic individuals have exceptional intellectual skills by most standards.

Many autistic individuals do not realize that others may have different thoughts, plans and perspectives than their own. For example, a person with autism may be asked to show a photograph of an object to another person. Rather than turning the picture around to face the other person, the person with autism, may instead, show the back of the photograph. In this example, the persons with autism can view the picture but does not realize that the other person has a different perspective or point of view.

Causes of Autism

Although there is no known unique cause of autism, there is growing evidence that autism can be caused by a variety of problems including:

- genetic influence
- viruses, particularly those associated with vaccinations
- damage to the cerebellum (portion of the brain close to the brain stem
- environmental factors (not fully proven)

Physical Differences

- Brain abnormalities
- Decreased levels of serotonin in blood and cerebral spinal fluid

- Very acute sensory system that produces sensory overloads
- Possibly a yeast called *candida albicans* in their intestinal tract.

Sensory Impairments

- May act as deaf
- May have fear of sound
- May stare at lights
- May be insensitive to pain
- May dislike contact with textures and people
- May lick and/or smell things

Many autistic individuals seem to have an impairment in one or more of their senses. This impairment can involve the auditory, visual, tactile, taste, vestibular, olfactory (smell) and proprioceptive senses. These senses may be hypersensitive, hyposensitive or may result in the person experiencing interference such as in the case of tinnitus (a persistent ringing or buzzing in the ears). As a result, it may be difficult for individuals with autism to process incoming sensory information properly.

Sensory impairments may also make it difficult for the individual to withstand normal stimulation. An example of sensory abnormalities is hypersensitive hearing. About 40% of individuals with autism experience discomfort when exposed to certain sounds or frequencies. These individuals often cover their ears and/or tantrum after hearing sounds such as a baby's cry or the sound of a motor. In contrast, some parents have suspected their child with autism of being deaf because they appeared unresponsive to sounds.

According to persons with autism, their disability is linked directly to the senses. While their eyes, ears, nose and skin can seem normal, it is now believed that when sensory messages reach the brain, they are not linked into an understandable picture of the outside world. They describe how the touch of another human being can be excruciating, smells can be overpowering, hearing can hurt, sight can be distorted and tastes may be too strong. In other words, their world can be a world of pain.

The receiving of faulty messages about the world around them leads to a lack of understanding of speech and gesture and hence a lack of ability to communicate. Because of the missing link in understanding, autistic persons appear to be withdrawn and seem to live in an isolated world of their own. Moreover, the frustration caused by the inability to communicate often leads to disturbed behavior.

Many autistic individuals also have a narrow or focused attention span; this has been termed stimulus over-selectivity. Basically, their attention is focused on only one, often irrelevant, aspect of an object. For example, they may focus on the color of a utensil, and ignore other aspects such as the shape. In this case, it may be difficult for a person with autism to discriminate between a fork and a spoon if he/she attends only to the color. Since attention is the first stage in processing information, failure to attend to the relevant aspects of an object or person may limit one's ability to learn about objects and people in one's environment.

The above principle is important to police officers and others who are trying to initiate a conversation with someone with autism. For most people, it takes a short period of time, less than a second or two, to redirect attention from one stimulus to another in the environment. In contrast, autistic individuals continue to attend to a stimulus even when prompted for redirection, and they may take three to five seconds or longer to shift their attention. It is thought that many persons with autism have difficulty directing their attention to changes in their surroundings, and by the time they do shift their attention, they lose information regarding context and content. An inability to shift attention in a timely manner may result in their not hearing the first sentence or two that someone else might say. For example, if a person with autism is focusing on an object of any kind and a police officer asks him/her a question, it may take a few seconds before he/she can redirect their attention and listen to the officer. As a result, the person has difficulty understanding the officer because he/she did not attend to the first few sentences. Therefore, it is considered a good practice to repeat the first two sentences of a conversation.

Communicating with Persons with Autism

As mentioned earlier, persons with autism tend to have extreme limitations with both expressive and receptive language. The police officer might consider the following tips when attempting to communicate with a person with autism.

- Do not use physical contact
- Be patient
- The person with autism may lack awareness of or attention to others, may have a stand-offish manner
- May be unable to make eye contact
- May parrot responses of others.
- Use simple language, speak slowly and clearly.
- Use concrete terms and ideas.
- Repeat simple questions, allowing time (10-15 seconds) for a response.
- Proceed slowly and give praise and encouragement.
- Do not attempt to physically stop self-stimulating behavior.
- Talk indirectly, look away and act indifferent.
- Use symbols or objects when talking.

When the person with autism is speaking, the autistic individual needs to know that he/she is being heard. How do you listen without antagonizing him/her? Standing calmly by, without looking intently at the person with autism. The officer should keep in mind that each individual with autism is unique and may act or react differently. Please contact a responsible person who is familiar with the individual, particularly when attempting to solicit important information.

Suggested Activity using the Trainee's Guide:

- Check your own general knowledge about autism on page 14 in the Trainee's Guide and answer the questions on page 15. Compare your answers with the answers at the bottom of page 17.

KEY POINTS

- There may be a wide discrepancy between chronological age and intellectual development.
- The majority of persons with autism are oversensitive to stimuli produced by at least one of the sensory organs (sound, smell, touch).
- Autism is usually accompanied with reduced adaptive skills.
- Persons with autism tend not to make eye contact.
- Repetitive behavior is a signal of sensory overload.
- Persons with autism have a limited attention span.
- Persons with autism have difficulty switching attention from one subject to another.
- Persons with autism tend to focus on specific aspects of an object and not see the entire picture.
- Police officers should repeat the first one or two sentences after beginning a conversation.
- Police officers or anyone should not try to stop self-stimulating behavior.
- Persons with autism may parrot the responses of others.
- May use a stand-offish manner.
- May have severe delays in language development.
- Persons with autism do not like to be touched. Touch is pain.
- May not understand their rights.
- May have difficulty remembering facts or details of offenses.
- May become anxious in new situations.
- May not understand the consequences of their actions.
- May have impaired social behavior, impaired language skills, sensory impairments and may have a fascination for repetition.
- Autism is found more frequently in men.

INCIDENT INVOLVING A POLICE OFFICER AND AN ADULT WITH CEREBRAL PALSY

This event occurred in Fort Worth, Texas, during June of 1996. The central character of this incident stopped at a convenience store on his way to work to purchase gasoline for his car. During the brief period of filling the gas tank, a police officer stopped at the same store to purchase a cup of coffee. The office observed the gas customer as walking with considerable sway and in addition heard his slurred speech when speaking to the attendant during the period of paying for the gasoline.

The gasoline customer returned to his car and exited the lot of the convenience store. The police officer quickly left the store, got in his car and began following the man who had just purchased the gasoline. Within a distance of three blocks, the officer pulled the man over and asked him to get out of his car. Again the officer observed the swaying and heard the man answer his questions with very slurred speech. The suspect tried to explain to the officer that he was a victim of cerebral palsy. The officer was unaware of the condition and felt sure the man was intoxicated. He placed the man under arrest and transported him to jail.

At the jail, the suspect placed a telephone call to a case worker at United Cerebral Palsy. The case worker immediately traveled to the jail and readily convenience officers that the suspect was a client of their agency and that his gait disturbance along with unusual speech were manifestations of his life-long disability. Officers apologized and the man was released.

Outcome: Besides officers being embarrassed over this incident and their type of action, their perception by the public was certainly not enhanced.

Remedy: Sensitivity training for all department personnel regarding cerebral palsy. This training must make the key point that persons with cerebral palsy reflect the entire range of intellectual potential and work in productive jobs. The broken speech and gait disturbance can be manifestations of conditions other than intoxication, and in this instance are major characteristics that accompany cerebral palsy.

Cerebral Palsy

Objectives

Performance Objective:

Given a subject with Cerebral Palsy involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the standards on page 24 in the Trainee's Guide. Include such factors as general information, identification, communication and community resources.

Enabling Objectives:

1. Demonstrate general knowledge of the unique factors of persons with cerebral palsy.
2. Role play with another participant with cerebral palsy in a simulated situation.

Identifying Persons with Cerebral Palsy

It is usually easy to identify persons with CP through observable physical manifestations, chief of which is gait disturbance. These persons can have normal intelligence. Physical manifestations can be limited to certain areas of the body; i.e., upper body, lower body, right side, left side, one arm or all. CP can be present in varying degrees. Persons with CP have problems in processing information in terms of where they (and their limbs) are physically and where they perceive themselves to be; therefore, there may be some unusual posturing. Some persons with CP have genius intelligence, yet only with recent innovations is this factor detected. A person with CP may have the following characteristics:

- Stiff and jerky movements
- Unsteady and shaky
- Poor balance
- Trouble holding themselves in an upright, steady position
- Random, involuntary movements
- Experience seizures
- Muscle imbalance in one of their eyes (lazy eye)

What is Cerebral Palsy?

Cerebral Palsy (CP) is a functional disorder caused by damage to the brain during pregnancy, delivery or shortly after birth. Sometimes injuries to a baby's brain happens while the baby is still in the mother's womb (before birth). The injury might be caused by an injection or by an accident in which the mother is hurt. If a mother has a medical problem such as high blood pressure or diabetes, this can also cause problems with the baby. There may be problems during birth, such as the baby not getting enough oxygen, or a difficult delivery in which the baby's brain is injured. Problems after birth may happen when a baby is born too soon (premature delivery)

and his/her body is not ready to live outside the mother's womb. Even babies born at the right time can have infections, or bleeding in their brain which causes a brain injury because the brain is still developing even after birth.

The words ***cerebral palsy*** are used to describe a medical condition that affects control of the muscles. ***Cerebral*** means brain or anything in the head, and ***palsy*** means a disorder of movement or posture. Palsy also refers to anything wrong with control of the muscles or joints in the body. If someone has cerebral palsy it means that because of an injury to their brain that they are not able to use some of the muscles in their body in the normal way. Persons with CP may not be able to walk, talk, eat, or participate in other activities in the same ways that non-disabled persons do.

Cerebral Palsy is the term used to describe the motor impairment resulting from brain damage. Cerebral Palsy is caused by damage to the brain with the damage varying in location and extent. CP is a non-progressive disorder of motion and posture due to a brain insult or injury during the period of early brain growth (prenatal up to 5 years). No event is an absolute predictor of CP. Most sources report that a minimum of 50% of the cases result from trauma during birth. In addition, the major source of trauma appears to be severe asphyxia (a lack of sufficient oxygen to the brain). What is not clear is whether asphyxia causes cerebral palsy or that asphyxia is a symptom of an otherwise sick baby with other neurological problems.

Cerebral Palsy can affect different parts of the body, and can be manifested by a wide variety of movement problems. It can result in restricted movement or extraneous, uncontrolled movements. Spasticity, which refers to the inability of a muscle to relax occurs in about 60% on all cases of CP. Spasticity results in reduced movement due to an increased resistance of fast stretching muscles that give way. The distribution of affected body regions can vary with the most common including the trunk and all four extremities with the legs more affected than the arms. Most estimates of all persons with CP indicate that 35% to 45% experience seizures.

Individuals with CP frequently manifest nutritional deficiencies because of difficulties in swallowing. In addition, many of those affected have extra caloric needs. Approximately 1 in 8 have hearing defects. Many persons with CP have normal intelligence, yet appear to be retarded. It is common for persons to have better receptive (understanding) than expressive (speech) language skills.

Prevalence Rate of CP

The generally accepted incidence of CP is 5 per 2000 persons and this seems to remain constant in the United States. Life expectancy is normal and the estimated living American population, using the above formula, with CP is about 650,000.

- CP is not a disease, it is not inherited, it is not contagious, it does not get worse, neither is there a cure.
- About 25% of cases result from prenatal causes such as from a virus, unnecessary x-rays, drugs, anemia, lack of proper nutrition and premature delivery.

- About 40% of cases are caused by lack of oxygen or in injury during birth or shortly after.
- About 30% of the causes are unknown.
- Occurs to some degree in about 2.5 out of 1,000 live births.

The most important thing to remember is that cerebral palsy is not contagious and you do not develop CP later in life. It is caused by an injury to the brain near the time of birth. Cerebral palsy is generally classified according to the type of movement problem. Motor ability and coordination vary greatly from one person affected to another, and there are very few statements that hold true for all persons with CP. The word for the dominant type of movement or muscle coordination problem is often combined with the word for the component that seems to be most problematic for the person with CP. Thus generalizations about CP can only have meaning within the context of the following subgroups.

Types of Cerebral Palsy

Persons with CP have damage to the area of their brain that controls muscle tone. Depending on where their brain injury is and how big it is, their muscle tone may be too tight, too loose or a combination of the two. Muscle tone is what lets us keep our bodies in a certain position like sitting with our heads up to look at your instructor in this class. Changes in muscle tone let us move.

- **Spastic Cerebral Palsy** refers to the inability of a muscle to relax. If muscle tone is too high or too tight, the term spastic is used to describe the type of cerebral palsy. Persons with spastic CP have stiff and jerky movements because their muscles are too tight.
- **Ataxic Cerebral Palsy** refers to low muscle tone and poor coordination of movements. Persons with CP look very unsteady and shaky, similar to a tremor you might have seen in a very old person. They also often have very poor balance and may be very unsteady when they walk.
- **Athetoid Cerebral Palsy** is used to describe the type of CP when muscle tone is mixed - sometimes to high and sometimes too low. Therefore these individuals lack the ability to control the movement of a muscle. Persons affected have trouble holding themselves in an upright, steady position for sitting or walking, and often show lots of movement of their face, arms and upper body that they do not mean to make.
- **Rigidity** generally refers to persons who are quadriplegic which implies that all four extremities as well as trunk and neck muscles are impaired. The term *rigidity* is generally synonymous with stiffness.
- **Mixed CP** occurs when muscle tone is too low in some muscles and too high in other muscles.

Conditions that Frequently Accompany Cerebral Palsy

Because CP is a condition caused by damage to the central nervous system, many of the complications of CP are neurological. Persons with CP may also have orthopedic problems that affect the spine, bones, joints, muscles or other parts of the skeletal system. In addition, they may also have problems that are considered "secondary" to the neurological and orthopedic problems. One example of a secondary effect of CP is poor nutrition caused by the person's difficulty in swallowing. Other neurological problems associated with CP include:

- seizures and epilepsy
- mental retardation
- learning disabilities
- attention deficit-hyperactivity disorder
- hydrocephalus (enlargement of fluid-filled spaces surrounding the brain)
- behavior problems
- visual impairments
- hearing loss
- speech impairment
- swallowing difficulties

All of the above conditions have implications for the law enforcement official assisting/investigating a scene involving a person with CP. As mentioned earlier, slightly less than one-half may experience seizures. A seizure (also called a convulsion) occurs when bursts of disorganized electrical energy interfere with normal brain functioning. Electrical bursts of this sort can occur in different parts of the brain and can result in different kinds of seizures. The most common kind of seizure for the person with CP is the *grand mal seizure*. This is a generalized type of seizure involving the entire body. The officer needs to remember that this may involve a loss of consciousness, alternating rigidity and relaxation of muscles and a period of drowsiness or disorientation. Regardless of the disposal of the situation, the person must continue to receive the medication that assists with the control of the seizures.

Persons with CP may have intelligence within the entire range of possibilities. They do tend to experience difficulty with speech, partly because of the possibility of impaired hearing, and have difficulty in writing and problem solving that involves a concentrated focus. Much of what non-disabled persons perceive is the result of being able to freely move around objects and see all dimensions. Persons with CP generally are lacking in mobility skills and thus their perceptual skills may be not as well developed as their non-disabled counterparts.

In the discussion of spastic CP we talked about the inability of muscles to relax. Nearly one-half of the persons with spastic CP have a muscle imbalance in one of their eyes resulting in what is commonly called *cross-eye*. In addition, the absence of adequate oxygen during birth tends to impair vision. As many as 80 percent of the persons with CP suffer from a *lazy eye*.

Suggested Activity using the Learner's Guide:

- Check your own general knowledge about **cerebral palsy** on page 20, and answer the self-check questions on page 21. Compare your answers with the answers on page 23.

KEY POINTS

- Keep in mind that a range of possible situations exist with persons with cerebral palsy and the majority of confrontations do not involve a crime.
- The word *palsy* means a disorder of movement.
- CP is a static, non-progressive disorder of movement and posture due to injuries of the brain sustained during the early developmental period.
- Persons with CP have damage to the area of their brain that controls muscle tone.
- CP is not temporary, and it does not get worse.
- About 25% of cases result from prenatal causes such as from a virus, unnecessary x-rays, drugs, anemia, lack of proper nutrition or premature delivery.
- About 40% of cases are caused by lack of oxygen or an injury during birth or shortly after.
- About 30% of the causes are unknown.
- CP occurs to some degree in about 2.5 out of 1,000 live births.
- Persons with spastic CP have stiff and jerky movements because their muscles are too tight.
- Persons with spastic CP often have a hard time moving from one position to another or letting go of something in their hand.
- Persons with CP have poor balance and look very unsteady.
- Persons with CP have random, involuntary movements.
- Some persons with CP become very stiff, especially in the joints.
- Persons with CP may also have orthopedic problems that affect the spine, bones, joints, muscles, or other parts of the skeletal system.
- Persons with CP may experience seizures. The police must remember that this may involve a loss of consciousness, alternating rigidity and relaxation of muscles and a period of drowsiness or disorientation.
- Persons with CP may have intelligence within the entire range of possibilities.
- Persons with CP tend to experience difficulty with speech.
- Some persons with CP have a muscle imbalance in one of their eyes resulting in what is commonly called cross-eye or lazy eye.

INCIDENT INVOLVING POLICE OFFICERS AND A YOUNG ADULT WITH EPILEPSY

The following event occurred in April of 1978, in Canton Ohio. A female suspect was arrested by police officers of the Canton Police Department and brought to the police station in a patrol wagon. When the officers arrived at the station, the suspect was found sitting on the floor of the wagon. She was asked if she needed medical attention and responded with an incoherent remark. After she was brought inside the station for processing, she slumped to the floor on two occasions. Eventually, the police officers left the suspect lying on the floor to prevent her from falling again. After about an hour, the suspect was released from custody and taken by an ambulance (provided by her family) to a nearby hospital. The suspect, who had experienced an epileptic seizure in the patrol wagon, was diagnosed as suffering from several emotional ailments; she was hospitalized for one week and received subsequent outpatient treatment for an additional year.

Some time later, the suspect commenced legal action alleging many state law and constitutional claims against the city of Canton and its officials. Among these claims was one seeking to hold the city liable for its violation of rights under the Due Process Clause of the Fourteenth Amendment, which is the right to receive necessary medical attention while in police custody.

A jury trial was held in a district court on the suspect's claims. Evidence was presented indicating that municipal policy authorized shift commanders, at their discretion, to make determinations as to when to summon medical care for an injured detainee. In addition, testimony also suggested that Canton shift commanders were not provided with any special training (beyond first-aid training) to make a determination as to when to summon medical care for an injured detainee. The court rejected all of her claims except one which was the failure to provide her with medical treatment.

The case was appealed with the Court of Appeals concluding that a municipality can be found liable for a failure to train its police force, particularly when the lack of training is so reckless or grossly negligent that deprivations of persons' constitutional rights will likely result. The City of Canton appealed the case to the Supreme Court of the United States. At issue was the extent of a municipality's liability.

Outcome: The Supreme Court ruled that an inadequacy of police training may serve as the basis for liability where the failure to train its employees amounts to a deliberate indifference to the rights of its' inhabitants with whom the police come into contact. The larger issue is that city and departmental policy must have training programs that are adequate to meet the needs of the community, regardless of how specific the duties assigned to individual police officers or other employees. The City of Canton was found liable in civil court. The court found that a municipality is liable where itself causes the constitutional violation at issue, which in this case was the absence of an adequate training policy.

Remedy: Sensitivity training for police officers in recognizing and handling citizens with **epilepsy** is a necessity.

Epilepsy

Objectives

Performance Objective:

Given a subject with Epilepsy involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 30 in the Trainee's Guide. Include such factors as general information, identification, communication, and community resources.

Enabling Objectives:

1. Demonstrate your general knowledge of the unique factors of persons with epilepsy.
2. Role play with another participant with epilepsy in a simulated situation.

Identifying Persons with Epilepsy

In general, people with epilepsy:

- are indistinguishable from others until a seizure occurs;
- have normal intelligence, and are as articulate as any other member of the public except during a seizure;
- have jobs and typical social and familial relationships;
- are unable to interact with other people or to respond to the environment or directions during a seizure;
- most persons who have a history of seizures will wear a medical ID bracelet.

However, some people with epilepsy may have other physical disabilities including mental retardation, cerebral palsy, autism or mental illness. Additionally, persons may experience social problems such as poverty, homelessness, drug addiction or alcoholism. Because these problems may interfere with consistent access to seizure-preventing medicines, this population may be more likely to have seizures than other persons with epilepsy and to have them in settings or circumstances that will lead to police attention.

What is Epilepsy

Epilepsy is a word derived from the Greek term *epilepsia* which means to seize. The condition is a disorder of the brain with the major characteristic being seizures, due to an electrical outburst within the cells. Epilepsy is not a disease, nor is it contagious. These recurrent discharges affect the normal operation of the nervous system. The result of this electrical *storm* within the brain is a seizure. These attacks are typically manifested with a clouding of consciousness. The physical manifestations are called epileptic seizures, which is why epilepsy is sometimes called a seizure disorder. The unusual bursts of energy may occur in just one area of the brain (partial seizures), or may affect nerve cells throughout the brain (generalized seizures). Normal brain function cannot return until the electrical bursts subside.

What is the Difference Between Seizures and Epilepsy?

Seizures are a symptom of epilepsy. Epilepsy is the underlying tendency of the brain to produce sudden bursts of electrical energy that disrupt other brain functions. These electrical discharges may occur in one or more areas of the brain. Having a single seizure does not necessarily mean a person has epilepsy. High fever, severe head injury, lack of oxygen--a number of factors can affect the brain enough to cause a single seizure. Epilepsy, is an underlying condition that affects the delicate systems which govern how electrical energy behaves in the brain, leaving the person susceptible to recurring seizures.

The seizure is a reaction of the body to the abnormal electrical outbursts within the brain. Not all seizures are the result of epilepsy. Seizures can result from low blood sugar, infection, and fever, without a person having the condition. When seizures recur, when they are unpredictable and without apparent medical cause, it may be epilepsy. Seizures that result in motor disturbances are labeled *convulsions*. Seizures may involve disturbances in mental or physical areas of the body or both.

How is Epilepsy Treated?

Epilepsy may be treated with drugs, surgery or a special diet. Of these treatments, drug therapy is by far the most common, and is usually the first to be tried. A number of medications are currently used in the treatment of epilepsy, with each of these medications controlling different types of seizures. People who have more than one type of seizure may have to take more than one kind of drug, although doctors try to control seizures with one drug if possible. A seizure preventing drug won't work properly until it reaches a certain level in the body, and that level has to be maintained. It is important to follow the doctor's instructions very carefully as to when and how much medication should be taken. The goal is to keep the blood level high enough to prevent seizures, but not so high that it causes excessive sleepiness or other unpleasant side effects.

An ideal drug would be one that prevents or stops all seizures, does not sedate the person, is free of side effects and has no cumulative side effects. As such a drug does not exist, thus physicians balance gains obtained by using a particular drug against its side effects. The entire spectrum of side effects is possible including trouble with balance and walking when blood levels of some common drugs are excessively high. Other side effects include making the skin itch, noticeable smell in perspiration and breath and involuntary eye movements.

Prevalence Rate of Epilepsy

The prevalence of epilepsy varies by source with some figures ranging as high as 3%. At a minimum it is found in approximately 1 out of every 100 persons. One reason that this figure varies is because of the stigma and prejudice associated with this disorder. One out of every 10 persons will have at least a single seizure at some point in their life and for 80 percent of those it will be their only seizure. Persons with isolated seizures are not classified has having epilepsy. The rates of epilepsy are higher in males than in females. The frequency among individuals of Afro-American heritage is higher than for traditional American whites. Males have a higher tendency

to receive genetic traits, yet the reasons for persons of color to have elevated rates are thought to be many, including poorer perinatal care. The intelligence range for persons with epilepsy, as measured by IQ tests is the same as the general population.

Types of Seizures

Many types of seizures exist with most sources generally using two major categories that are further subdivided into nine seizure classifications. The categories and classifications are used as guidelines to determine the severity of a person's epilepsy. Knowledge of the common characteristics of a seizure classification helps to anticipate the victim's actions during the seizure. The nine seizure classifications are:

Generalized Seizures

- Tonic-Clonic (grand mal)
- Absence (petit mal)
- Myoclonic
- Tonic
- Clonic
- Atonic

Partial Seizures

- Simple-Partial Seizures (consciousness not impaired)
- Complex-Partial Seizures (consciousness impaired)
- Secondarily Generalized (partial onset evolving to generalized tonic-clonic seizures)

Responding to Persons During a Seizure Episode

Officers and criminal justice system personnel should follow standard safety precautions when approaching an unknown situation; however, where there is a possibility that a seizure is the cause of the behavior that is observed, they should:

- stay calm and assert authority to those in the surrounding area
- address the individual in a non-threatening tone to assess level of awareness and response
- look for a medical identification bracelet or necklace stating "epilepsy" or "seizure disorder"
- ask witnesses/bystanders what happened, and whether the individual has had similar episodes in the past or is known to have epilepsy
- guide individual away from hazards and away from crowds when possible, while speaking in a calming, reassuring tone
- remember that the most likely danger in dealing with someone having a seizure is that he/she will strike out aggressively in response to physical restrain.

Symptoms Seen During or Following a *Generalized* Seizure

- A cry at the onset caused by air being forced out of the lungs by contracting muscles
- Falling to the ground, stiffening of the body
- Rhythmic muscle contractions of the whole body, which gradually slow and then stop
- Temporary cessation of breathing and possible development of bluish tinge to the skin
- Slow return to consciousness, accompanied by noisy breathing
- Post seizure confusion, fatigue, temporary inability to respond
- Possible belligerence and irritability following the seizure

Actions to Take During a *Generalized* Seizure

During the seizure the person may fall, become stiff and make jerking movements. The person's complexion may become pale or bluish.

- DO help the person lie down and put something soft under the head.
- DO remove any eyeglasses and loosen any tight clothes.
- DO clear the area of sharp or hard objects.
- DO NOT force anything into the person's mouth.
- DO NOT try to restrain the person as you cannot stop the seizure.

Actions to Take After the *Generalized* Seizure

- DO turn the person to one side to allow saliva to drain from the mouth.
- DO arrange for someone to stay nearby until the person is fully awake.
- DO NOT offer the person any fluid or drink.

Partial Seizures

Partial seizures involve only a part of the brain. They may or may not impair consciousness. Those seizures where consciousness is not impaired throughout the seizure are called *simple* partial seizures. Seizures that involve an impairment of consciousness are called *complex* partial seizures.

Symptoms During or Following a *Partial* Seizure

- Starts with a blank stare, followed by chewing or twitching movements of the mouth or face.
- Communication becomes blocked or disordered.
- May mumble, look dazed, unaware of surroundings and sometimes understand spoken work but be unable to respond.
- Actions appear clumsy, not directed, may wander without regard to location or barriers in path, and may make repeated movements with part of the body or fumble with clothing.

- Actual seizure lasts a couple of minutes, confusion remains for up to half an hour afterwards.
- Less common symptoms may be screaming, crying, moaning, laughing, apparent fear, disrobing, unnatural movements of arms or legs.

Actions to take during a partial seizure

- DO try to remove harmful objects from the person's pathway or coax the person away from them.
- DO NOT try to stop or restrain the person.
- DO NOT agitate the person.
- DO NOT approach the person if you are alone and the person appears to be angry or aggressive. This is very unusual.

Note: *After the seizure* the person may be confused or disoriented after regaining consciousness and should not be left alone until fully alert.

Seizures and the Need for Medical Attention

- If the person does not start breathing within 1 minute after the seizure ends (begin mouth-to-mouth resuscitation).
- If a generalized tonic-clonic seizure lasts more than 2 minutes.
- If the person has one seizure right after another.
- If the person is injured.
- If the person requests an ambulance.

Differences Between Mental Illness and/or Intoxication and a Seizure

Mental illness tends to be a constant problem, or changes relatively slowly and intoxication has a slow, observable onset. People with epilepsy will experience a sudden change from normal to impaired. Both persons who are mentally ill and/or intoxicated will be able to interact with the officer on some level. During a generalized or complex partial seizure meaningful interaction with an officer, or with anyone else is unlikely. Speech, comprehension and information processing are all affected by seizure activity in the brain.

Intoxicated people will have a strong smell of alcohol present while someone having a seizure may or may not have had an alcoholic drink prior to the seizure. Acknowledgment is also made that seizures can also occur in alcoholic persons. When this is the case, the person should be managed in the same manner by attempting to protect them from injury, and not forcibly apply restraint.

Where and When do Encounters Occur?

Seizures can occur anywhere. Many occur at home in settings that would not led to police interaction. Seizures are more likely to come to the attention of law

enforcement when they happen in public facilities such as restaurants, stores, recreation centers, banks, in custody, during questioning, in police cruisers, at the site of an accident or other stressful event, and frequently at homeless shelters.

Encounters can take place at any time during police shifts. Seizures caused by alcoholism or illegal drug use may be more likely to occur during the evening hours. The weekends and holidays are peak periods for seizures because persons have exhausted their medication.

Suggested Activity using the Trainee's Guide:

- Check your own general knowledge about **epilepsy and seizures** on page 26 and answer the self-check questions on page 27. Compare your answers with the answers on page 29.

KEY POINTS

- The role of the police officer in the majority of occasions involving persons with epilepsy will be that of a helper rather than an enforcer.
- People with epilepsy are generally intelligent, perceptive and articulate as any other member of the public, although occurrence of a seizure will mask these attributes until the person is fully recovered.
- People with epilepsy will experience a sudden change form normal to impaired.
- Persons with epilepsy can be helped with medications which must be maintained when in jail.
- Seizures are a symptom of epilepsy.
- Epileptic seizures are the result of electrical discharges in one or more areas of the brain.
- Medication for epilepsy may cause side effects, i.e., trouble with balance and walking, itchy skin, noticeable smell in perspiration and breath and involuntary eye movements.
- There are two main categories of seizures: generalized and partial.
- The majority of persons with epilepsy are not dangerous to others.
- It is important for the police officer to remember that behavior is out of control for persons experiencing epileptic seizures.
- The most fundamental problem in identifying a person with epilepsy is the fact that too often the symptoms are mistaken for daydreaming or deliberate wrongdoing.
- Epilepsy can momentarily cause confused behavior and an inability to respond to police questioning.
- Seizures usually last only a couple of minutes; when police respond to a call the seizure is typically over, yet the person may appear confused, agitated or belligerent.

- Do not try to restrain someone during a seizure.
- Check for a medical identification bracelet.
- Seizures can occur anywhere.
- Seizures caused by alcoholism or illegal drug use may be more likely to occur during the evening hours, weekends and holidays because persons have exhausted their medication.
- Don't Panic. The first thing to remember is to remain calm during the episode.
- Keep the seizure victim safe during the seizure.
- Time the seizure. How long did the seizure last? Keeping a record of the length of the seizure, along with recording the characteristics of the seizure, allows the individual and medical staff to check for any changes in the seizure behavior.
- Remove any sharp objects or furniture within reach of the individual.
- Place a pillow under the person's head.
- Stay with the seizure victim. Make sure that the individual comes out of the seizure safely. The person could sustain a serious injury from trauma, or stop breathing.

INCIDENT INVOLVING POLICE OFFICERS AND AN ADULT WITH A HEARING IMPAIRMENT

This incident occurred in Fort Worth, Texas, in September, 1994. A police officer stopped a driver for a traffic violation at night. The police officer approached the vehicle and shined his flashlight in the face of the driver. The driver tried to indicate by speech and gestures that he was deaf. He could not hear the officer's instructions, and with the light blinding his eyes, could not read the officer's lips. The suspect tried to communicate that if the officer would turn the light away, instead of directly into his eyes, he could read his lips. The officer seemed to fail to understand the consequence of his action with the light.

The deaf man started to reach into his glove compartment for his proof of auto insurance card when the officer pulled his weapon, pointed it at the driver's head, sprayed him with pepper spray, pulled him out of the car, and threw him on the ground, knocking him unconscious, according to the driver. He was arrested and taken to the police station, where, he alleges, he was further assaulted by other officers.

He was held in jail for fifteen hours before he was provided access to a TTY to make a telephone call. He was provided no interpreter during this time, and did not know what were the charges against him, nor was he informed of his rights. He had been charged with assault on a peace officer. The deaf man claims he never touched the officer, but rather the officer assaulted him. A family friend called the local social service agency for deaf people and received a referral to an attorney. An internal investigation of the officers' actions was called for.

Outcome: Such incidents are detrimental to both the suspect and to the image of the police department. Experiences with police officers are very emotional ones for persons with hearing impairments because of the communication difficulties. Besides officers being embarrassed by the incident, which was within their realm of their training, public trust was diminished.

Remedy: Sensitivity training for police officers in recognizing and handling citizens who are deaf or have a hearing impairment. This training must include knowledge of the legal requirement of making an interpreter available to the suspect in a timely manner. Through the interpreter, the suspect must be informed of the charges, his/her rights, and have the same rights as anyone else with respect to communicating with an attorney and/or family.

Hearing Impairments

Objectives

Performance Objective:

Given a subject with a hearing impairment involved in a problem situation, demonstrate an understanding of persons with this developmental disability according to the performance standards on page 36 in the Trainee's Guide. Include such factors as general information, identification, communication and community resources.

Enabling Objectives:

1. Demonstrate your general knowledge of the unique factors of persons with hearing impairments.
2. Role play with another participant with hearing impairments in a simulated situation.

Identifying the Hearing Impaired

- The person appears alert but fails to respond to any sounds.
- The person points to the ears, or to the ear and mouth, and might also shake their head.
- The person speaks in a flat or harsh, unintelligible monotone voice.
- In the case of a traffic check, the officer should keep his/her eyes on the person's hands and be aware that the person might be reaching for a pen and pad to write.

Background: Hearing Impairments

Man's need to communicate with his fellow man is possibly his greatest uniquely human need. The sense of hearing, the primary means by which infants develop language and speech, serves as the basis of human communication, with its attendant social and intellectual interaction throughout a person's life. Impairment of hearing, whether it be congenital deafness, acquired loss through illness or the gradual loss of hearing in later years, results not only in the primary disability of impaired communication but also the companion disability of the social stigma imposed on the hearing impaired by hearing people.

Only recently were some of the misconceptions gradually eliminated; but many remain as some continue to use the terms *deaf and dumb* and *deaf-mute*. The past two decades have been marked by a remarkable explosion of medical and techno-logical advances in fields that offer assistance to persons with hearing loss, and by the enlightened interest in the educational and sociological betterment of persons with hearing loss.

Defining Deafness & Hearing Impairment

The word *deaf* is commonly applied to both partial and complete inability to hear. The term *hard of hearing* frequently alludes to both profound losses that can qualify as legal deafness and to moderate or even mild losses. One can be deaf because of the inability to hear amplified pure-tone signals above a certain volume or without reference to hearing capacity. A person is considered deaf when they cannot hear enough to recognize sounds or word combinations even when they are amplified. Generally, persons are considered hard of hearing when capable of only partial recognition of the spoken language or if conversation must be close and unusually clear to be understood.

One very important functional difference between the deaf and hard of hearing is that **deaf implies the absence of sound**. The person who is deaf can rarely follow speech and knows of that limitation. The person who is hard of hearing thinks they can recognize speech with the result frequently being a misunderstanding of what was said. The results may yield miscommunication, an inaccurate appearance of sagging intelligence or indifference.

The human ear is very unique. It packs into a space smaller than a lime an electronics system with capabilities approximating as many wires as the telephone system of a city with a population of 300,000, and in many ways is more versatile and reliable than a telephone system. Ears can spot the location of sound, even if it is distant or behind us, despite the fact that we cannot move our ears as animals do. Ears collect and decipher whispers, sounds of gunfire or help us distinguish one musical note from another.

Causes of Hearing Loss?

Hearing loss can be inherited (genetic), congenital (acquired in the womb) or acquired after birth. The most common form of hereditary loss results in a blockage of the oval window that restricts passage of sound from the middle ear to the inner ear. Hereditary deafness is believed to be responsible for approximately one-half of all childhood deafness. Persons born with Down syndrome frequently have hearing loss attributable to genetic factors.

Congenital deafness is caused by blood-group incompatibilities of the mother and the fetus and viral infections contracted by the mother during pregnancy. A baby is most likely to be born with hearing problems if the mother suffers an infection during the first three months of pregnancy as all the components of the ear are completely developed during this brief period.

Acquired hearing loss can result from a variety of causes including childhood diseases such as measles and mumps, and assorted viral infections that can cause inflammation of the inner ear. Hearing loss can also be acquired from such day-to-day items such as industrial gases, excessive noise over a prolonged period, and nicotine or excessive use of aspirin.

Types of Hearing Disorders

The physiological complexity of the hearing mechanism may be thought of as a device converting sound waves into mechanical energy, then into fluid energy, and

finally into electrical energy in the form of nerve impulses. This unique feat is accomplished by the three main parts of the ear: (a) the outer and middle ear mechanism. (b) the inner ear and (c) the central auditory system of the central nervous system.

A hearing disorder involving the outer or middle ear mechanism, the mechanical portion of the system, results in what is termed a *conductive* hearing loss. This type of loss is similar to the volume on the radio being set very low with little or no distortion of sound. Conductive hearing loss results from a blockage or breakdown in the canal, eardrum, or middle ear bones. Hearing tests on people with conductive deafness show the inner ear or nerve function to be normal but the air conduction to be reduced. Persons with conductive hearing loss usually speak very softly because sound generated by their own voice appears louder owing to direct conduction through the skull into the inner ear. Conductive hearing loss can often be cured by surgery or improved through the use of a hearing aid.

The second major category of disorders involves the inner ear. When the inner ear is affected a *sensory* deafness results, and if the nerve of hearing is involved then a *neural* hearing loss occurs. Usually these two groups are lumped together under the term *sensorineural*. Sensorineural hearing loss cannot be cured by surgery or helped by the use of a hearing aid. This type is often likened to a radio with the dial not being properly tuned. Amplification of sound for these persons over amplifies the often normal low frequencies in an effort to improve the high frequency loss and results in a noisy jumble. Another characteristic of sensorineural deafness is that it is quite commonly for the sound, when amplified to become painful. This type of loss can cause one to be irritated by the raspy, fuzzy qualities of any sound. Persons affected often mistake words like *fifty* for *sixty* or *twenty* for *thirty*. Because these persons often become irritated, they frequently "switch off" their concentration.

Prevalence of Hearing Impairments

- Frequently described as the nation's number one disabling condition.
- Approximately 50 percent of persons age 75 plus have a significant degree of hearing loss.
- As a developmental disability, hearing impairment occurs at the rate of approximately six per 1,000 persons or six-tenths of one percent (.6%).
- When all age categories are combined, 7.64 percent of the general population have a hearing impairment.

Types of Communication

- Lipreading - is the least reliable method of communication. Lipreading is about 30% effective in understanding what is being said.
- Reading & writing notes - is an effective means of communication, but you must be patient. A deaf person's grammar might be hard to understand.
- Sign language - is the preferred mode of communication. Ask a nearby friend or family to assist in interpreting. If none is available, have the dispatcher find an interpreter.

As in any situation involving the victim of a crime, one of the police officer's first priorities is to obtain a description of the suspect. With a deaf victim, it is essential to decide on the method of communication immediately. **Lipreading** is the least reliable of the three communication methods. Only about 30 percent of what is said can be lip-read. If the person is able to lip-read, make sure there is adequate light, so the person can see your lips. The officer should look directly at the person when speaking. Be aware that a moustache or using chewing gum makes it more difficult for an individual to read your lips.

Writing notes are often an effective means of communication. The officer should note that the grammar of persons who are deaf is often hard to understand. Writing notes will require patience on the officer's part.

Sign language is the preferred method of communication. This requires the presence of an interpreter. Often there is a family member or friend with these skills that can provide assistance. The police dispatcher should maintain a list of interpreters available in your area.

Police Encounters

- Victim of a crime
- Witness to a crime or an incident may be more helpful than his or her counterpart.
- Motor Vehicle Accident
- Traffic checks - it is a normal reaction for the person to instantly reach for a pen and pad located in his/here pocket or glove compartment. Drivers who are deaf are taught that when stopped by the police that they should place their hands on the steering wheel.

The Rights of a Deaf Suspect.

Persons with hearing impairments have a legal right to a professional interpreter. Family members and friends are not professionals. The officer should never attempt to question a person who is hearing impaired without an interpreter. A written Miranda may not be sufficient. The Miranda warning is written at an eighth grade level, while the average deaf person reads at a fifth or sixth grade level. Suspects also have the right to make a telephone call using a telecommunication device for the deaf (TDD).

Communication Tips

- Decide on the method of communication immediately (lipreading, writing notes or sign language)
    - If lipreading is chosen, make sure there is adequate light, look directly at the person, and be aware that a moustache or chewing gum makes lipreading difficult.

  - If writing is chosen, remember that a deaf person's grammar is different and might be hard to understand.
  - If sign language is used, find an interpreter
- Be patient.
- Face the deaf person when you speak
- Listen to both sides of the story--deaf persons have noted that police officers tend to ignore them.

Key Points

- Persons with hearing impairments try to cope with auxiliary means of communication such as sign language, lip reading, reading and writing.
- Coping methods are unique to the individual.
- Lip reading is the least reliable method of communication.
- Sign language is the preferred method of communication.
- Persons with hearing impairment can be mistaken for persons who are senile, mentally ill or mentally retarded.
- It is a state law in Texas that deaf persons be provided with a qualified interpreter involving any governmental procedure (Code of Civil Procedure 1965, (d), Art. 38.31).
- You, not the interpreter, are the one talking to the deaf person.
- Remember that different categories of DD require differing techniques in initial contacts.
- Persons with hearing impairments are no more likely to commit a crime than anyone else.
- There are over 40 million persons in the United States with significant hearing impairment; approximately two-thirds of that number represent hearing loss associated with advanced age.
- Persons are considered hard of hearing when capable of only partial recognition of the spoken language or if conversation must be close and unusually clear to be understood.
- They are more like you, that unlike you.
- The real handicap of deafness is being cut off from normal means of acquiring and transmitting language.
- Persons who have lost their hearing due to advanced age usually do not know how to use sign language.

EVALUATION OF TRAINING MATERIAL

Participant:

Please take a few moments and complete the following evaluation. Police officer training about persons with developmental disabilities is relatively new, and thus so is any training material, including what has been used for this session. As you complete this brief form, please consider only the material. This is not an evaluation of the academy instructor or the physical environment where the training was offered. The material will be refined based on these evaluations. Please indicate your opinion on this course of study as related to the following topics by circling the appropriate number.

	Poor						Excellent
Breadth of material	1	2	3	4	5	6	7
Depth of coverage	1	2	3	4	5	6	7
Speed of presentation	1	2	3	4	5	6	7
Time spent on lectures	1	2	3	4	5	6	7
Appropriateness of transparencies	1	2	3	4	5	6	7
Effectiveness of videos	1	2	3	4	5	6	7
Effectiveness of outside speaker	1	2	3	4	5	6	7
Quality of class activities	1	2	3	4	5	6	7
Level of language	1	2	3	4	5	6	7
Clarity of objectives	1	2	3	4	5	6	7
Sequencing of topics	1	2	3	4	5	6	7
Effectiveness in meeting your needs	1	2	3	4	5	6	7
Value of discussions	1	2	3	4	5	6	7
Value of handouts	1	2	3	4	5	6	7

Comments

Strengths of this training:_____

_____

_____

Weaknesses of this training:_____

_____

_____

Topics that should be added or strengthened:_____

_____

Topics that should be deleted:_____

_____

QUIZ ON LIFE-LONG DISABILITIES

1. Which of the following is the correct general term for a life-long disability?
   a. mental retardation
   b. autism
   c. developmental disability
   d. cerebral palsy

2. Which of the following is **not** a reliable indicator of a developmental disability?
   a. speech fluency
   b. physical appearance
   c. appropriate dress
   d. reduced adaptive skills

3. The majority of crimes committed by persons with a developmental disabilities are:
   a. petty offenses and public disturbances
   b. homicide
   c. burglary
   d. none of the above

4. About what proportion of all Americans have a developmental disability?
   a. 10%
   b. 20%
   c. 25%
   d. 5%

5. Mental retardation as expressed by an I.Q. (intelligence quotient) score means?
   a. mental age is same as chronological age
   b. mental age is greater than chronological age
   c. mental age is less than chronological age
   d. none of the above

6. What proportion of mental retardation is attributed to environmental factors?
   a. 3%
   b. 5%
   c. 25%
   d. 80+%

7. A basic principle to use in interviewing a person with mental retardation is:
   a. exercise patience
   b. use rapid-fire questioning
   c. use an area with lots of activity
   d. increase sound level

8. A person with which of the following disabling condition may easily appear intoxicated?
   a. mental retardation
   b. autism
   c. cerebral palsy
   d. epilepsy

9. A person with which of the following conditions is oversensitive to stimuli produced by a sensory organ?
   a. mental retardation
   b. autism
   c. cerebral palsy
   d. epilepsy

10. Which of the following statements is **not** true about cerebral palsy?
   a. it is contagious
   b. it is a movement disorder
   c. may have normal intelligence
   d. may have a lazy eye

11. What is a disability?
   a. an impairment that inhibits functioning
   b. acute physical illness
   c. condition imposed by society
   d. result of deconditioning

12. A person with which of the following conditions is most likely to experience inappropriate behavioral episodes?
   a. hearing impaired
   b. mental retardation
   c. cerebral palsy
   d. autism

13. Seizures are always a symptom of:
   a. mental retardation
   b. epilepsy
   c. cerebral palsy
   d. hearing impairments

14. Which of the following disorders is characterized by gait disturbance?
   a. mental retardation
   b. autism
   c. cerebral palsy
   d. deafness

15. Which of the following is **not** a characteristic of a person with autism?
    a. reduced adaptive skills
    b. reduced communication skills
    c. engages in repetitive behavior
    d. enjoy being touched by others

16. A typical response by persons with autism to sensory overload is?
    a. to smile
    b. begin repetitive movements
    c. laughter
    d. increased eye contact

17. Which of the following is true about persons with epilepsy?
    a. tend to be of normal intelligence
    b. can be relatively free from seizures with use of medication
    c. may affect persons of all ages
    d. all of the above.

18. Which of the following is true about persons with mental retardation?
    a. easily exploited by others
    a. frequently confess to a crime that they may not have committed
    c. tend not to be violent
    d. all of the above

19. The majority of persons with mental retardation are in which category?
    a. mild
    b. moderate
    c. severe
    d. none of the above

20. Which of the following actions should **not** be done when assisting someone during a seizure episode?
    a. make sure they are not swallowing their tongue
    b. remove objects that might cause injury to the person
    c. lay person on their side
    d. direct on-lookers away from the victim

21. Which of the following statements is **not** true about persons with hearing loss?
    a. advanced age is the largest category
    b. all persons so affected are retarded
    c. the greatest hardship is communication loss
    d. deafness is total hearing loss

22. Which of the following statements are true regarding developmental disabilities?
    a. different categories require differing communication techniques
    b. generally present from birth
    c. more like than unlike their non-disabled peers
    d. all of the above

23. A person with hearing loss may possibly be mistaken for?
    a. a person with mental illness
    b. a person with autism
    c. a person being uncooperative
    d. all of the above

24. Which of the following is the preferred communication method with persons with hearing impairments?
    a. lipreading
    b. sign language
    c. reading and writing
    d. use of symbols

25. Which age group with hearing impairments tends **not** to know sign language?
    a. persons who are elderly when their hearing impairments developed
    b. middle age persons who were born with hearing impairments
    c. high school age youth who were born with hearing impairments
    d. none of the above